CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1370	**Date: April 10, 2014**
	Change Request 8651

Transmittal 1363, dated March 28, 2014, is being rescinded and replaced by Transmittal 1370, dated April 10, 2014, to instruct DME MACs that the effective and implementations dates have been changed to May 27, 2014 from the original date of July 1 and 7, 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 - February 1, 2014 version 3.0.4

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the contractors and 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 Code Updates published on February 1, 2014.

EFFECTIVE DATE: July 1, 2014 for VMS, May 27, 2014 for DME MACs
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2014 for VMS, May 27, 2014 for DME MACs

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

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

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1370	Date: April 10, 2014	Change Request: 8651

Transmittal 1363, dated March 28, 2014, is being rescinded and replaced by Transmittal 1370, dated April 10, 2014, to instruct DME MACs that the effective and implementations dates have been changed to May 27, 2014 from the original date of July 1 and 7, 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 - February 1, 2014 version 3.0.4

EFFECTIVE DATE: July 1, 2014 for VMS, May 27, 2014 for DME MACs
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2014 for VMS, May 27, 2014 for DME MACs

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 3.0.4 on February 1, 2014. This update is based on November 1, 2013 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code updates as posted at the WPC website.

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

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/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8651.1	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the current version of *CORE Code Combinations* for use with CAQH CORE 360 Rule - *February 2014 CORE Code Combinations v3.0.4.* Note: The document is available at: http://www.caqh.org/CORECodeCombinations.php				X			X		
8651.2	Contractors and Shared System Maintainers shall make the necessary changes per attached Change Log that lists all updates since version 3.0.3 that was implemented under CR 8365. Note: Attachment I - Change Log for v 3.0.4				X			X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8651.3	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 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				X	

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Lauren Vandegrift, 410-786-4882 or Lauren.Vandegrift@cms.hhs.gov , sumita sen, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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: 1)

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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Version	Description	Publication Date
3.0.0	CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) based on published CARC & RARC lists as of June 2011, balloted and approved by CORE members	06/01/2012
3.0.1	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2011	01/31/2013
3.0.2	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of March 2013	05/24/2013
3.0.3	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of July 2013	10/01/2013
3.0.4	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2013	02/01/2014

Detailed Description of Updates for the February 2014 v3.0.4 *CORE Code Combinations*		
CORE-defined Business Scenario	**Adjustment**	**Detailed Description of Adjustment**
Business Scenario #1 – Additional Information	·3 RARC descriptions modified	· Description of RARC N102 was modified
		· Description of RARC N178 was modified
		· 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
		· 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

Detailed Description of Updates for the February 2014 v3.0.4 *CORE Code Combinations*		
CORE-defined Business Scenario	**Adjustment**	**Detailed Description of Adjustment**
		· 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
Business Scenario #2 – Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim	· 1 CARC description modified	· Description of CARC 16 was modified
	· 1 CARC added	· CARC P7 was added
	· 4 RARCs added	· RARC N685 was associated with CARC 16
		· 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 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
	· 2 RARC descriptions 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 50 due to deactivation of RARC
		· RARC N627 was removed from association with CARC 60 due to deactivation of RARC
		· RARC N627 was removed from association with CARC 95 due to deactivation of RARC
		· RARC N365 was removed from association with CARC 96 due to deactivation of RARC
		· RARC N627 was removed from association with CARC 174 due to deactivation of RARC
		· RARC N627 was removed from association with CARC 222 due to deactivation of RARC
		· RARC N627 was removed from association with CARC 233 due to deactivation of RARC
		· RARC N627 was removed from association with CARC 249 due to deactivation of RARC
		· RARC N365 was removed from association with CARC 256 due to deactivation of RARC
	· 8 CARCs added	· CARC 258 was added
		· CARC P2 was added
		· CARC P3 was added
		· CARC P4 was added
		· CARC P16 was added
		· CARC P17 was added
		· CARC P20 was added
		· CARC P21 was added
	· 47 RARCs added	· RARC N684 was associated with CARC 8
		· RARC N30 was associated with CARC 258
		· RARC N103 was associated with CARC 258
		· RARC N193 was associated with CARC 258
		· RARC N612 was associated with CARC P4
		· 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 N479 was associated with CARC P21
		· RARC N576 was associated with CARC P21

Detailed Description of Updates for the February 2014 v3.0.4 *CORE Code Combinations*		
CORE-defined Business Scenario	**Adjustment**	**Detailed Description of Adjustment**
		· 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 N668 was associated with CARC P21
Business Scenario #4 – Benefit for Billed Service 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 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 M144 was associated with CARC P14
		· RARC N19 was associated with CARC P14
		· RARC N20 was associated with CARC P14
		· RARC N67 was associated with CARC P14
		· RARC N111 was associated with CARC P14
		· RARC N390 was associated with CARC P14
		· RARC N525 was associated with CARC P14

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

Table of Contents

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

Introduction

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

- CORE is establishing a *minimum* set of CORE-defined Claim Adjustment/Denial Business Scenarios as defined in the rule and a *maximum* set of CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC[1] Combinations to convey detailed information about the payment adjustment or denial. This document specifies the maximum set of CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations. The specific Business Scenarios in the rule were selected as they represent some of the most confusing and high volume scenarios that are exchanged between health plans and providers. Identifying a *maximum* set of code combinations for use with these Business Scenarios was selected for similar reasons – to reduce confusion and drive industry approaches to a long-standing problem.
- When using the CORE-defined Business Scenarios, entities are not allowed to add to the code combinations associated with each Business Scenario as this set of CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations represents a *maximum* set. The only exception to this maximum is when the respective code committees create a new code or adjust an existing code; then the new or adjusted code can be used immediately with the Business Scenarios and the CORE Process for Maintaining the CORE-defined Claim Adjustment Reason Code, Remittance Advice Remark Code & Claim Adjustment Group Code Combinations for updating the Code Combinations will review the ongoing use of these codes within the maximum set of codes for the Business Scenarios. (See §3.5 of the Phase III CORE 360 Uniform Use of CARC and RARC Codes (835) Rule Version 3.0.0.)
- When the specific CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations within a Business Scenario are not applicable to meet the health plan's business requirements in describing the payment adjustment or denial, the health plan is not required to use the combinations. Should a health plan want to create new Business Scenarios which do not conflict with the existing CORE-defined Business Scenarios, this rule does not prohibit that, but it is expected the health plan will send the new Scenarios for consideration in an updated rule.
- In the case that additional CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations for an existing CORE-defined Business Scenario is needed beyond what is currently included in the maximum set, then such code combinations must be requested in accordance with the CORE process for updating the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*
- Consistent with the v5010 X12 835 or the CARC definition itself, not all CARCs require a RARC. Therefore, any CARC in the CORE-required Code Combination tables may be used without the corresponding RARC, except for CARCs that require RARCs as specified by the v5010 X12 835 or the CARC definition itself.
- The pharmacy industry adjudicates claims differently than the medical sector of health care, both with regard to process as well as with regard to codes used in that process. The pharmacy industry adjudicates claims and reports the results in real time using the NCPDP Telecommunication Standard. Using the NCPDP Telecommunication Standard, pharmacies send a real time request and receive an immediate real time response from the processor. If the claim is rejected, the NCPDP Reject Codes must be used consistently and uniformly across all trading partners. Each NCPDP Reject Code is tied to a specific reason/field in the NCPDP Telecommunication standard. Agreement on the use of these Reject Codes allows the pharmacy to ensure all required data for real time adjudication is available. Once the adjudication process is completed, the processor then reports the final result of adjudication via a real time response which includes payment information, payment reductions, etc. If necessary, adjustments are reported on the v5010 X12 835 using an appropriate CARC code which the pharmacy industry has agreed upon. NCPDP has created a mapping document to tie claim response fields to CARC Codes in the v5010 X12 835. The reporting of a rejected claim in a v5010 X12 835 transaction occurs only rarely, given that the pharmacy already has the rejection information from the real time processing of the claim and the v5010 X12 835 does not require the subsequent reporting of a rejected claim. Any such reporting is based on non-real time claims processing and mutual trading partner agreement using the NCPDP Reject Codes combined with CARC 16. (See §2.2 of the Phase III CORE 360 Uniform Use of CARC and RARC Codes (835) Rule Version 3.0.0.)

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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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/chart.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N678	Missing post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N678	Missing post-operative images/visual field results.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI
165	Referral absent or exceeded.	N630	Referral not authorized by attending physician).	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M141	Missing physician certified plan of care.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M143	The provider must update license information with the payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA112	Missing/incomplete/invalid group practice information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA122	Missing/incomplete/invalid initial treatment date.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N3	Missing consent form.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N26	Missing itemized bill/statement	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N28	Consent form requirements not fulfilled.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N29	Missing documentation/orders/notes/summary/report/chart.	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
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 for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N191	The provider must update insurance information directly with payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N197	The subscriber must update insurance information directly with payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N202	Additional information/explanation will be sent separately.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N205	Information provided was illegible.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N206	The supporting documentation does not match the claim.	CO or PI
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/chart.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N236	Incomplete/invalid pathology report.	CO or PI
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N460	Incomplete/invalid Discharge Summary.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N461	Missing Nursing Notes.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N462	Incomplete/invalid Nursing Notes.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N463	Missing support data for claim.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N464	Incomplete/invalid support data for claim.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N465	Missing Physical Therapy Notes/Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N466	Incomplete/invalid Physical Therapy Notes/Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N467	Missing Report of Tests and Analysis Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N468	Incomplete/invalid Report of Tests and Analysis Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N473	Missing certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N474	Incomplete/invalid certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N475	Missing completed referral form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N476	Incomplete/invalid completed referral form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N477	Missing Dental Models.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N478	Incomplete/invalid Dental Models.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N481	Missing Models.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N482	Incomplete/invalid Models.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N483	Missing Periodontal Charts.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N484	Incomplete/invalid Periodontal Charts.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N485	Missing Physical Therapy Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N486	Incomplete/invalid Physical Therapy Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N487	Missing Prosthetics or Orthotics Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N488	Incomplete/invalid Prosthetics or Orthotics Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N489	Missing referral form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N490	Incomplete/invalid referral form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.	CO or PI
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N667	Missing prescription	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N668	Incomplete/invalid prescription	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N678	Missing post-operative images/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 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).	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	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	M29	Missing 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	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	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	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	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	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	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	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	M127	Missing 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).	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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 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).	M131	Missing physician financial relationship form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M132	Missing pacemaker registration form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M135	Missing/incomplete/invalid plan of treatment.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M141	Missing physician certified plan of care.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M143	The provider must update license information with the payer.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not 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	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	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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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 NCPDP	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N29	Missing documentation/orders/notes/summary/report/chart.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 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).	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 Reject Reason Code, or Remittance Advice	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 Reject Reason Code, or Remittance Advice	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark 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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 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	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	N202	Additional information/explanation will be sent separately.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N205	Information provided was illegible.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N206	The supporting documentation does not match the claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N221	Missing Admitting History and Physical report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N222	Incomplete/invalid Admitting History and Physical report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N223	Missing documentation of benefit to the patient during initial treatment period.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark 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	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 (may be comprised of either the NCPDP	N232	Incomplete/invalid itemized bill/statement.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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 (may be comprised of either the NCPDP	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark 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

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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 Reject Reason Code, or Remittance Advice	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 (may be comprised of either the NCPDP	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark 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

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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 (may be comprised of either the NCPDP	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 (may be comprised of either the NCPDP	N452	Incomplete/invalid Admission Summary Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N453	Missing Consultation Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N454	Incomplete/invalid Consultation Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	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

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N459	Missing Discharge Summary.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N460	Incomplete/invalid Discharge Summary.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N461	Missing Nursing Notes.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N462	Incomplete/invalid Nursing Notes.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N463	Missing support data for claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N464	Incomplete/invalid support data for claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N465	Missing Physical Therapy Notes/Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N466	Incomplete/invalid Physical Therapy Notes/Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N467	Missing Report of Tests and Analysis Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark 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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N478	Incomplete/invalid Dental Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N481	Missing Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N482	Incomplete/invalid Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N483	Missing Periodontal Charts.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N484	Incomplete/invalid Periodontal Charts.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N485	Missing Physical Therapy Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N486	Incomplete/invalid Physical Therapy Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N487	Missing Prosthetics or Orthotics Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N488	Incomplete/invalid Prosthetics or Orthotics Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N489	Missing referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N490	Incomplete/invalid referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N493	Missing Doctor First Report of Injury.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N494	Incomplete/invalid Doctor First Report of Injury.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N495	Missing Supplemental Medical Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N496	Incomplete/invalid Supplemental Medical Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N497	Missing Medical Permanent Impairment or Disability Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N499	Missing Medical Legal Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N500	Incomplete/invalid Medical Legal Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N542	Missing income verification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N543	Incomplete/invalid income verification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N555	Missing medication list.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N556	Incomplete/invalid medication list.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation **Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.**				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark 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

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

[3]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 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is	N519	Invalid combination of HCPCS modifiers.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare	N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is	N644	Reimbursement has been made according to the bilateral procedure rule.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is	N657	This should be billed with the appropriate code for these services.	CO or PI
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.	CO or PI
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835	N657	This should be billed with the appropriate code for these services.	CO or PI
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835	N517	Resubmit a new claim with the requested information.	CO or PI
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835	N657	This should be billed with the appropriate code for these services.	CO or PI
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO or PI
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO or PI
13	The date of death precedes the date of service.			CO or PI
14	The date of birth follows the date of service.			CO or PI
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517	Resubmit a new claim with the requested information.	CO or PI
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice 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 or has submission/billing error(s) which is needed	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M22	Missing/incomplete/invalid number of miles traveled.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M24	Missing/incomplete/invalid number of doses per vial.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M44	Missing/incomplete/invalid condition code.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M45	Missing/incomplete/invalid occurrence code(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M46	Missing/incomplete/invalid occurrence span code(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	M47	Missing/incomplete/invalid internal or document control number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M50	Missing/incomplete/invalid revenue code(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M51	Missing/incomplete/invalid procedure code(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M52	Missing/incomplete/invalid "from" date(s) of service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M53	Missing/incomplete/invalid days or units of service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M54	Missing/incomplete/invalid total charges.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M56	Missing/incomplete/invalid payer identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M59	Missing/incomplete/invalid "to" date(s) of service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M60	Missing Certificate of Medical Necessity.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M62	Missing/incomplete/invalid treatment authorization code.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M67	Missing/incomplete/invalid other procedure code(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	M77	Missing/incomplete/invalid place of service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M79	Missing/incomplete/invalid charge.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M81	You are required to code to the highest level of specificity.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M122	Missing/incomplete/invalid level of subluxation.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	M124	Missing indication of whether the patient owns the equipment that requires the part or supply.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M126	Missing/incomplete/invalid individual lab codes included in the test.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	M129	Missing/incomplete/invalid indicator of x-ray availability for review.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	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 or has submission/billing error(s) which is needed for adjudication. Do not use this code for	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA04	Secondary payment cannot be considered without the identity of or payment	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA30	Missing/incomplete/invalid type of bill.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO or PI
16	Claim/service lacks information or has 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 submission/billing error(s) which is needed	MA33	Missing/incomplete/invalid noncovered days during the billing period.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA35	Missing/incomplete/invalid number of lifetime reserve days.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA36	Missing/incomplete/invalid patient name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA37	Missing/incomplete/invalid patient's address.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA39	Missing/incomplete/invalid gender.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA40	Missing/incomplete/invalid admission date.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA41	Missing/incomplete/invalid admission type.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA42	Missing/incomplete/invalid admission source.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA43	Missing/incomplete/invalid patient status.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA58	Missing/incomplete/invalid release of information indicator.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA60	Missing/incomplete/invalid patient relationship to insured.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA64	Our records indicate that we should be the third payer for this claim. We cannot process	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA65	Missing/incomplete/invalid admitting diagnosis.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA66	Missing/incomplete/invalid principal procedure code.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA69	Missing/incomplete/invalid remarks.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA70	Missing/incomplete/invalid provider representative signature.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA71	Missing/incomplete/invalid provider representative signature date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA90	Missing/incomplete/invalid employment status code for the primary insured.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA92	Missing plan information for other insurance.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA94	Did not enter the statement "Attending physician not hospice employee" on the claim	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA99	Missing/incomplete/invalid Medigap information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA100	Missing/incomplete/invalid date of current illness or symptoms.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At	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
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA112	Missing/incomplete/invalid group practice information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA120	Missing/incomplete/invalid CLIA certification number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA121	Missing/incomplete/invalid x-ray date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA122	Missing/incomplete/invalid initial treatment date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA128	Missing/incomplete/invalid FDA approval number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N20	Service not payable with other service rendered on the same date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N27	Missing/incomplete/invalid treatment number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N31	Missing/incomplete/invalid prescribing provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N32	Claim must be submitted by the provider who rendered the service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N34	Incorrect claim form/format for this service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N37	Missing/incomplete/invalid tooth number/letter.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N39	Procedure code is not compatible with tooth number/letter.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	N46	Missing/incomplete/invalid admission hour.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N48	Claim information does not agree with information received from other insurance	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N50	Missing/incomplete/invalid discharge information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N53	Missing/incomplete/invalid point of pick-up address.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N54	Claim information is inconsistent with pre-certified/authorized services.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N56	Procedure code billed is not correct/valid for the services billed or the date of service	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N57	Missing/incomplete/invalid prescribing date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	N58	Missing/incomplete/invalid patient liability amount.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N62	Dates of service span multiple rate periods. Resubmit separate claims.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N63	Rebill services on separate claim lines.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N64	The "from" and "to" dates must be different.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	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 or has submission/billing error(s) which is needed	N75	Missing/incomplete/invalid tooth surface information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N76	Missing/incomplete/invalid number of riders.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N77	Missing/incomplete/invalid designated provider number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N147	Long term care case mix or per diem rate cannot be determined because the patient ID	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N148	Missing/incomplete/invalid date of last menstrual period.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N150	Missing/incomplete/invalid model number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N152	Missing/incomplete/invalid replacement claim information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N153	Missing/incomplete/invalid room and board rate.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N161	This drug/service/supply is covered only when the associated service is covered.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N182	This claim/service must be billed according to the schedule for this plan.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N188	The approved level of care does not match the procedure code submitted.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N190	Missing contract indicator.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N203	Missing/incomplete/invalid anesthesia time/units.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	N207	Missing/incomplete/invalid weight.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N208	Missing/incomplete/invalid DRG code.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N209	Missing/incomplete/invalid taxpayer identification number (TIN).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N229	Incomplete/invalid contract indicator.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N245	Incomplete/invalid plan information for other insurance.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N247	Missing/incomplete/invalid assistant surgeon taxonomy.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N248	Missing/incomplete/invalid assistant surgeon name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N249	Missing/incomplete/invalid assistant surgeon primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N250	Missing/incomplete/invalid assistant surgeon secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N251	Missing/incomplete/invalid attending provider taxonomy.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N252	Missing/incomplete/invalid attending provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N253	Missing/incomplete/invalid attending provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N254	Missing/incomplete/invalid attending provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N255	Missing/incomplete/invalid billing provider taxonomy.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N256	Missing/incomplete/invalid billing provider/supplier name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N258	Missing/incomplete/invalid billing provider/supplier address.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N260	Missing/incomplete/invalid billing provider/supplier contact information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N261	Missing/incomplete/invalid operating provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N262	Missing/incomplete/invalid operating provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N263	Missing/incomplete/invalid operating provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N264	Missing/incomplete/invalid ordering provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N265	Missing/incomplete/invalid ordering provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N266	Missing/incomplete/invalid ordering provider address.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	N267	Missing/incomplete/invalid ordering provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N268	Missing/incomplete/invalid ordering provider contact information.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N269	Missing/incomplete/invalid other provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N270	Missing/incomplete/invalid other provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N271	Missing/incomplete/invalid other provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N272	Missing/incomplete/invalid other payer attending provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N273	Missing/incomplete/invalid other payer operating provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N274	Missing/incomplete/invalid other payer other provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N275	Missing/incomplete/invalid other payer purchased service provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N276	Missing/incomplete/invalid other payer referring provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N277	Missing/incomplete/invalid other payer rendering provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N278	Missing/incomplete/invalid other payer service facility provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N279	Missing/incomplete/invalid pay-to provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N281	Missing/incomplete/invalid pay-to provider address.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N282	Missing/incomplete/invalid pay-to provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N283	Missing/incomplete/invalid purchased service provider identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N284	Missing/incomplete/invalid referring provider taxonomy.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N285	Missing/incomplete/invalid referring provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N287	Missing/incomplete/invalid referring provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N288	Missing/incomplete/invalid rendering provider taxonomy.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N289	Missing/incomplete/invalid rendering provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N291	Missing/incomplete/invalid rendering provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N292	Missing/incomplete/invalid service facility name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N293	Missing/incomplete/invalid service facility primary identifier.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	N294	Missing/incomplete/invalid service facility primary address.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N295	Missing/incomplete/invalid service facility secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N296	Missing/incomplete/invalid supervising provider name.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N297	Missing/incomplete/invalid supervising provider primary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N298	Missing/incomplete/invalid supervising provider secondary identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N299	Missing/incomplete/invalid occurrence date(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N300	Missing/incomplete/invalid occurrence span date(s).	CO or PI
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	N324	Missing/incomplete/invalid last seen/visit date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N325	Missing/incomplete/invalid last worked date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N326	Missing/incomplete/invalid last x-ray date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N327	Missing/incomplete/invalid other insured birth date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N328	Missing/incomplete/invalid Oxygen Saturation Test date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N329	Missing/incomplete/invalid patient birth date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N330	Missing/incomplete/invalid patient death date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N331	Missing/incomplete/invalid physician order date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N332	Missing/incomplete/invalid prior hospital discharge date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N333	Missing/incomplete/invalid prior placement date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N334	Missing/incomplete/invalid re-evaluation date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N335	Missing/incomplete/invalid referral date.	CO or PI
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 submission/billing error(s) which is needed	N337	Missing/incomplete/invalid secondary diagnosis date.	CO or PI
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 submission/billing error(s) which is needed	N339	Missing/incomplete/invalid similar illness or symptom date.	CO or PI
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 submission/billing error(s) which is needed	N341	Missing/incomplete/invalid surgery date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N342	Missing/incomplete/invalid test performed date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N345	Date range not valid with units submitted.	CO or PI
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 submission/billing error(s) which is needed	N349	The administration method and drug must be reported to adjudicate this service.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC)	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N359	Missing/incomplete/invalid height.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N378	Missing/incomplete/invalid prescription quantity.	CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed	N382	Missing/incomplete/invalid patient identifier.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N388	Missing/incomplete/invalid prescription number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N418	Misrouted claim. See the payer's claim submission instructions.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N433	Resubmit this claim using only your National Provider Identifier (NPI).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N434	Missing/Incomplete/Invalid Present on Admission indicator.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N439	Missing anesthesia physical status report/indicators.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N440	Incomplete/invalid anesthesia physical status report/indicators.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N443	Missing/incomplete/invalid total time or begin/end time.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N471	Missing/incomplete/invalid HIPPS Rate Code.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N521	Mismatch between the submitted provider information and the provider information	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N547	A refund request (Frequency Type Code 8) was processed previously.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N554	Missing/Incomplete/Invalid Family Planning Indicator.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N562	The provider number of your incoming claim does not match the provider number on the	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N575	Mismatch between the submitted ordering/referring provider name and the	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N595	Records reflect the injured party did not complete an Assignment of Benefits for this	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N596	Records reflect the injured party did not complete a Medical Authorization for this	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N653	The date of injury does not match the reported date of loss.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N657	This should be billed with the appropriate code for these services.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	OA or CO
69	Day outlier amount.			CO or PI

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835	N630	Referral not authorized by attending physician).	CO or PI
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	CO or PI
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N684	Payment denied as this is a specialty claim submitted as a general claim.	CO or PI
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	M81	You are required to code to the highest level of specificity.	CO or PI
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed	N657	This should be billed with the appropriate code for these services.	CO or PI
199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	CO or PI
206	National Provider Identifier - missing.			CO or PI
207	National Provider identifier - Invalid format.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO or PI
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

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

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim **Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.**				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
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

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

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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.	CO, PI or PR
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N684	Payment denied as this is a specialty claim submitted as a general claim.	CO, PI or PR
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
20	This injury/illness is covered by the liability carrier.			CO, PI or PR
21	This injury/illness is the liability of the no-fault carrier.			CO, PI or PR
22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	CO, PI or PR
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)			OA
26	Expenses incurred prior to coverage.	N30	Patient ineligible for this service.	CO, PI or PR
26	Expenses incurred prior to coverage.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
26	Expenses incurred prior to coverage.	N128	This amount represents the prior to coverage portion of the allowance.	CO, PI or PR
26	Expenses incurred prior to coverage.	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
26	Expenses incurred prior to coverage.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
26	Expenses incurred prior to coverage.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
26	Expenses incurred prior to coverage.	N652	The date of service is before the date of loss.	CO, PI or PR
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
27	Expenses incurred after coverage terminated.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N619	Coverage terminated for non-payment of premium.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
29	The time limit for filing has expired.	N30	Patient ineligible for this service.	CO, PI or PR
31	Patient cannot be identified as our insured.			CO, PI or PR
32	Our records indicate that this dependent is not an eligible dependent as defined.	MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	CO, PI or PR
32	Our records indicate that this dependent is not an eligible dependent as defined.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
32	Our records indicate that this dependent is not an eligible dependent as defined.	N129	Not eligible due to the patient's age.	CO, PI or PR
33	Insured has no dependent coverage.	N578	Coverages do not apply to this loss.	PR
34	Insured has no coverage for newborns.			CO, PI or PR
35	Lifetime benefit maximum has been reached.	N45	Payment based on authorized amount.	CO, PI or PR
35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	CO, PI or PR
39	Services denied at the time authorization/pre-certification was requested.			CO, PI or PR
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			CO, PI or PR
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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/chart.	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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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/chart.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N45	Payment based on authorized amount.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N607	Service provided for non-compensable condition(s).	CO or PR
53	Services by an immediate relative or a member of the same household are not covered.			CO, PI or PR
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO, PI or PR
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI, or PR
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	CO, PI or PR
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO, PI or PR
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N623	Not covered when deemed unscientific/unproven/outmoded/experimental /excessive/inappropriate.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy	N623	Not covered when deemed unscientific/unproven/outmoded/experimental /excessive/inappropriate.	CO or PI
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N633	Additional anesthesia time units are not allowed.	CO or PI
59	Processed based on multiple or concurrent procedure rules. (For example multiple	N644	Reimbursement has been made according to the bilateral procedure rule.	CO or PI
59	Processed based on multiple or concurrent procedure rules. (For example multiple	N670	This service code has been identified as the primary procedure code subject to the	CO or PI
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	CO, PI or PR
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			CO or PI
78	Non-Covered days/Room charge adjustment.			CO, PI or PR
89	Professional fees removed from charges.	N200	The professional component must be billed separately.	CO, PI or PR
95	Plan procedures not followed.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
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

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96 [8]	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M2	Not paid separately when the patient is an inpatient.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M13	Only one initial visit is covered per specialty per medical group.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M37	Not covered when the patient is under age 35.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M41	We do not pay for this as the patient has no legal obligation to pay for this.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI or PR

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M82	Service is not covered when patient is under age 50.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M87	Claim/service(s) subjected to CFO-CAP prepayment review.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M89	Not covered more than once under age 40.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M90	Not covered more than once in a 12 month period.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information	M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M117	Not covered unless submitted via electronic claim.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M121	We pay for this service only when performed with a covered cryosurgical ablation.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M134	Performed by a facility/supplier in which the provider has a financial interest.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information 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,	MA54	Physician certification or election consent for hospice care not received timely.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA67	Correction to a prior claim.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code	MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N7	Processing of this claim/service has included consideration under Major Medical provisions.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code	N15	Services for a newborn must be billed separately.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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 either the NCPDP Reject Reason [sic] Code,	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 either the NCPDP Reject Reason [sic] Code,	N35	Program integrity/utilization review decision.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N43	Bed hold or leave days exceeded.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N45	Payment based on authorized amount.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N54	Claim information is inconsistent with pre-certified/authorized services.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N55	Procedures for billing with group/referring/performing providers were not followed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N59	Please refer to your provider manual for additional program and provider information.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N61	Rebill services on separate claims.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N70	Consolidated billing and payment applies.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N81	Procedure billed is not compatible with tooth surface code.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N87	Home use of biofeedback therapy is not covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N90	Covered only when performed by the attending physician.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N92	This facility is not certified for digital mammography.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N95	This provider type/provider specialty may not bill 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	N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be 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	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N110	This facility is not certified for film mammography.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N113	Only one initial visit is covered per physician, group practice or provider.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N117	This service is paid only once in a patient's lifetime.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N129	Not eligible due to the patient's age.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be 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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC8	CARC Description[6]	RARC	RARC Description[7]	ASC X12 CAGC
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N143	The patient was not in a hospice program during all or part of the service dates billed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N157	Transportation to/from this destination is not covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N158	Transportation in a vehicle other than an ambulance is not covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N163	Medical record does not support code billed per the code definition.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code	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 Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information	N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N188	The approved level of care does not match the procedure code submitted.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N194	Technical component not paid if provider does not own the equipment used.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N198	Rendering provider must be affiliated with the pay-to provider.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N202	Additional information/explanation will be sent separately.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code	N383	Not covered when deemed cosmetic.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N408	This payer does not cover deductibles assessed by a previous payer.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	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	N410	Not covered unless the prescription changes.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N424	Patient does not reside in the geographic area required for this type of payment.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N425	Statutorily excluded service(s).	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N426	No coverage when self-administered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N428	Not covered when performed in this place of service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N429	Not covered when considered routine.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N431	Not covered with this procedure.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N441	This missed/cancelled appointment is not covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N442	Payment based on an alternate fee schedule.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N507	Plan distance requirements have not been met.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N525	These services are not covered when performed within the global period of another service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N528	Patient is entitled to benefits for Institutional Services only.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N529	Patient is entitled to benefits for Professional Services only.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N567	Not covered when considered preventative.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N569	Not covered when performed for the reported diagnosis.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N576	Services not related to the specific incident/claim/accident/loss being reported.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N578	Coverages do not apply to this loss.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N588	The patient has instructed that medical claims/bills are not to be paid.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835	N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N607	Service provided for non-compensable condition(s).	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	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,	N624	The associated Workers' Compensation claim has been withdrawn.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N630	Referral not authorized by attending physician	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N633	Additional anesthesia time units are not allowed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N636	Adjusted because this is reimbursable only once per injury.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N637	Consultations are not allowed once treatment has been rendered by the same provider.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N647	Adjusted based on diagnosis-related group (DRG).	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N653	The date of injury does not match the reported date of loss.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N665	Services by an unlicensed provider are not reimbursable.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	CO, PI or PR
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	CO, PI or PR
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N576	Services not related to the specific incident/claim/accident/loss being reported.	CO, PI or PR
111	Not covered unless the provider accepts assignment.			CO, PI or PR
114	Procedure/product not approved by the Food and Drug Administration.	N623	Not covered when deemed unscientific/unproven/outmoded/experimental /excessive/inappropriate.	CO, PI or PR
115	Procedure postponed, canceled, or delayed.			CO, PI or PR
117	Transportation is only covered to the closest facility that can provide the necessary care.			CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
119	Benefit maximum for this time period or occurrence has been reached.	M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M89	Not covered more than once under age 40.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
119	Benefit maximum for this time period or occurrence has been reached.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N636	Adjusted because this is reimbursable only once per injury.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
128	Newborn's services are covered in the mother's Allowance.			CO, PI or PR
138	Appeal procedures not followed or time limits not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.	CO, PI or PR
150	Payer deems the information submitted does not support this level of service.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
153	Payer deems the information submitted does not support this dosage.			CO, PI or PR
154	Payer deems the information submitted does not support this day's supply.			CO, PI or PR
155	Patient refused the service/procedure.			CO, PI or PR
157	Service/procedure was provided as a result of an act of war.			CO, PI or PR
158	Service/procedure was provided outside of the United States.	N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.	PR
159	Service/procedure was provided as a result of terrorism.			CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N59	Please refer to your provider manual for additional program and provider information.	CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.	CO, PI or PR
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N607	Service provided for non-compensable condition(s).	CO, PI or PR
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N647	Adjusted based on diagnosis-related group (DRG).	CO, PI or PR
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M143	The provider must update license information with the payer.	CO, PI or PR
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N90	Covered only when performed by the attending physician.	CO, PI or PR
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO, PI or PR
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N665	Services by an unlicensed provider are not reimbursable.	CO, PI or PR
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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
198	Precertification/authorization exceeded.	M62	Missing/incomplete/invalid treatment authorization code.	CO, PI or PR
198	Precertification/authorization exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO, PI or PR
198	Precertification/authorization exceeded.	N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
200	Expenses incurred during lapse in coverage.	N619	Coverage terminated for non-payment of premium.	CO, PI or PR
200	Expenses incurred during lapse in coverage.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
202	Non-covered personal comfort or convenience services.	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N567	Not covered when considered preventative.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N569	Not covered when performed for the reported diagnosis.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
212	Administrative surcharges are not covered.	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N587	Policy benefits have been exhausted.	CO, PI or PR
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N633	Additional anesthesia time units are not allowed.	CO, PI or PR
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	N555	Missing medication list.	CO, PI or PR
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	N556	Incomplete/invalid medication list.	CO, PI or PR
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.			CO, PI or PR
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)			PR
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.			CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N202	Additional information/explanation will be sent separately.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N202	Additional information/explanation will be sent separately.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N630	Referral not authorized by attending physician).	CO, PI or PR
246	This non-payable code is for required reporting only.	N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.	CO, PI or PR
249	This claim has been identified as a readmission. (Use only with Group Code CO)			CO
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	N202	Additional information/explanation will be sent separately	CO, PI or PR
256	Service not payable per managed care contract.	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.	CO, PI or PR
256	Service not payable per managed care contract.	M37	Not covered when the patient is under age 35.	CO, PI or PR

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
256	Service not payable per managed care contract.	M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
256	Service not payable per managed care contract.	M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	CO, PI or PR
256	Service not payable per managed care contract.	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR
256	Service not payable per managed care contract.	M81	You are required to code to the highest level of specificity.	CO, PI or PR
256	Service not payable per managed care contract.	M82	Service is not covered when patient is under age 50.	CO, PI or PR
256	Service not payable per managed care contract.	M89	Not covered more than once under age 40.	CO, PI or PR
256	Service not payable per managed care contract.	M90	Not covered more than once in a 12 month period.	CO, PI or PR
256	Service not payable per managed care contract.	M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.	CO, PI or PR
256	Service not payable per managed care contract.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO, PI or PR
256	Service not payable per managed care contract.	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
256	Service not payable per managed care contract.	MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.	CO, PI or PR
256	Service not payable per managed care contract.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
256	Service not payable per managed care contract.	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
256	Service not payable per managed care contract.	N117		CO, PI or PR
256	Service not payable per managed care contract.	N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR
256	Service not payable per managed care contract.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
256	Service not payable per managed care contract.	N202	Additional information/explanation will be sent separately	CO, PI or PR
256	Service not payable per managed care contract.	N246	State regulated patient payment limitations apply to this service.	CO, PI or PR
256	Service not payable per managed care contract.	N428	Not covered when performed in this place of service.	CO, PI or PR
256	Service not payable per managed care contract.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO, PI or PR
256	Service not payable per managed care contract.	N623	Not covered when deemed unscientific/unproven/outmoded/experimental /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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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
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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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
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
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
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.	N570	Missing/incomplete/invalid credentialing data	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.	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
B9	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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.			CO, PI or PR
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	CO, PI or PR
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
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 adjustment is at the Claim Level, the payer must send and	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 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	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 no	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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 no	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 adjustment	N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N576	Services not related to the specific incident/claim/accident/loss being reported.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N577	Personal Injury Protection (PIP) Coverage.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N578	Coverages do not apply to this loss.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N579	Medical Payments Coverage (MPC).	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N580	Determination based on the provisions of the insurance policy.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N582	Benefits suspended pending the patient's cooperation.	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	N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N585	Benefits are no longer available based on a final injury settlement.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N586	The injured party does not qualify for benefits.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N587	Policy benefits have been exhausted.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N588	The patient has instructed that medical claims/bills are not to be paid.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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	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
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	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	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	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	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	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	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	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	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N598	Health care policy coverage is primary.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N607	Service provided for non-compensable condition(s).	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N611	Claim in litigation. Contact insurer for more information.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N622	Not covered based on the date of injury/accident.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N650	This policy was not in effect for this date of loss. No coverage is available.	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	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N652	The date of service is before the date of loss.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N653	The date of injury does not match the reported date of loss.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N657	This should be billed with the appropriate code for these services.	CO, PI or PR

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan **Refers to situations where the billed service is not covered by the health plan.**				
CARC8	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N658	The billed service(s) are not considered medical expenses.	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	N661	Documentation does not support that the services rendered were medically necessary.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N665	Services by an unlicensed provider are not reimbursable.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N667	Missing prescription	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N668	Incomplete/invalid prescription	CO, PI or PR
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)			PR
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

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

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

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

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

Table 5-1				
Scenario #4: Benefit for Billed Service Not Separately Payable **Refers to situations where the billed service or benefit is not separately payable by the health plan.**				
CARC	**CARC Description[9]**	**RARC**	**RARC Description[10]**	**ASC X12 CAGC**
24	Charges are covered under a capitation agreement/managed care plan.			CO, PI or PR
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M2	Not paid separately when the patient is an inpatient.	CO, PI or PR
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	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 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
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 adjudicated. Note: Refer to the 835	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	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	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	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 Healthcare Policy Identification Segment	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

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.**				
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
97	The benefit for this service is included in the payment/allowance for another	N122	Add-on code cannot be billed by itself.	CO, PI or PR
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835	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	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 service/procedure that has already been	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	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	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 adjudicated. Note: Refer to the 835	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: Refer to the 835	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 adjudicated. Note: Refer to the 835	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

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.**				
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N626	New or established patient E/M codes are not payable with chiropractic care codes.	CO, PI or PR
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	CO, PI or PR
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO, PI or PR
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M2	Not paid separately when the patient is an inpatient.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment	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
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

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.	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: Refer to the 835	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 service/procedure that has been performed on	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 Healthcare Policy Identification Segment	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
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

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.	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

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

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

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.4 February 1, 2014

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

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

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

Table 6-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[11]**	**RARC**	**RARC Description[12]**	**ASC X12 CAGC**
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Not Applicable	For retail pharmacy the NCPDP External Code List must be used.[13]	CO or PI

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

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

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