CT Medical Assistance Program EOB Crosswalk Pharmacy & Non-Pharmacy

Pharmacy EOB Crosswalk

Non-Pharmacy EOB Crosswalk

gainwell

Pharmacy EOB X-Ref Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0000	INACTIVE ERROR CODE. MODIFIED		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0001	INTERNAL EDIT.		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0002	PROCESSED IN ERROR. CLAIM WILL BE REPROCESSED.		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0003	CLAIM DENIED. FIX ERRORS AND RESUBMIT		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	9/5/2015	12/31/2299
0022	ONE TIME EARLY REFILL OVERRIDE FOR HUSKY B CLIENT WITHOUT PA HAS BEEN UTILIZED.					1/1/2018	12/31/2299
0024	CLAIM BYPASSED OPIOID EDIT DUE TO TAXONOMY					7/1/2019	12/31/2299
0025	CLAIM BYPASSED OPIOID EDIT DUE TO DIAGNOSIS CODE					7/1/2019	12/31/2299
0027	CLAIM BYPASSED EDIT 0207 DUE TO PPE AUTO-PA.					1/1/2014	12/31/2299
0028	PRESCRIBING PROVIDER IN PROCESS OF ENROLLING.					1/1/2014	12/31/2299
0029	CLAIM BYPASSED EDIT 207 FOR MANUAL PA BP OR MED D					1/1/2014	12/31/2299
0030	CLAIM BYPASSED EDIT 207 FOR OUT OF STATE PROVIDER					1/1/2014	12/31/2299
0031	CLAIM BYPASSED EDIT 204 DUE TO NPI BYPASS		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0032	CLAIM BYPASSED EDIT 209 DUE TO NPI BYPASS					1/1/2014	12/31/2299
0033	CLAIM BYPASSED EDIT 207 DUE TO NPI BYPASS					1/1/2014	12/31/2299
0037	CLAIM BYPASSED EDIT 1042 DUE TO NPI BYPASS					1/1/2014	12/31/2299
0038	PROVIDER NOT ELIGIBLE TO RE-ENROLL REFILL-ONLY CLAIM PAID.					3/30/2016	12/31/2299
0039	CLAIM BYPASSED EDIT 0207 DUE TO NALOXONE RX					3/30/2016	12/31/2299
0040	CLAIM PAID BEYOND TIMELY FILING LIMIT DUE TO SPECIAL HANDLING		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0044	REBATE BYPASS DUE TO OTHER COVERAGE PYMT ON CLAIM					1/1/2021	12/31/2299

Pharmacy EOB X-Ref Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0052	PROGRAM RESTRICTIONS BYPASSED FOR OTC COVID TESTS					1/1/2022	12/31/2299
0057	CLAIM BYPASSED EDIT 207 DUE TO NDCS ON THE LIST OF CVP VACCINATIONS.					1/1/2023	12/31/2299
0059	CLAIM BYPASSED EDIT 0207 DUE TO VACCINE					1/1/2024	12/31/2299
0100	REDUCE TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)	1/1/2014	12/31/2299
0102	SERVICE IS NOT COVERED FOR ELIGIBILITY DETERMINATION.					1/1/2014	12/31/2299
0157	NDC IS MISSING.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0195	RETROACTIVE DATE	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0201	Billing provider identifier is missing.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0202	Billing provider identifier is invalid.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0203	Client identification number is missing.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0204	PRESCRIBING PROVIDER NOT AUTHORIZED TO PRESCRIBE	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0205	PRESCRIBING PROVIDER'S NPI DEA OR LICENSE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0206	SUBMITTED PRESCRIBER'S ID IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0207	PRESCRIBER NOT ENROLLED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0209	PRESCRIBER ID OF GROUP; RESUBMIT INDIVIDUAL'S NPI		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0210	DISPENSE AS WRITTEN INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0211	REFILL INDICATOR IS MISSING OR INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0212	PRESCRIPTION NUMBER IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0213	DATE PRESCRIPTION WRITTEN IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

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0214	DATE PRESCRIPTION WRITTEN IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0215	DATE DISPENSED IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0216	DATE DISPENSED IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0218	NDC IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0219	QUANTITY DISPENSED IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0220	QUANTITY DISPENSED IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0221	DAYS SUPPLY IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0222	DAYS SUPPLY IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

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0227	OTHER PAYER PAYMENT AMOUNT IS INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0237	PRESCRIBING PROVIDER IS A STUDENT OR RESIDENT AND MUST BE ENROLLED TO PRESCRIBE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0238	Client's last name is missing.		2 CO	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.)	1/1/2014	12/31/2299
0247	Exceeds maximum number of claim details allowed.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0255	CLIENT DATE OF BIRTH DISAGREES WITH SUBMITTED DATE OF BIRTH.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2016	12/31/2299
0256	DATE DISPENSED IS MORE THAN ONE YEAR OR SIX MONTHS FOR CONTROLLED SUBSTANCES					3/30/2016	12/31/2299
0260	UNITS OF SERVICE IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0268	DETAIL BILLED AMOUNT IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0269	DETAIL BILLED AMOUNT IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

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0341	DIABETIC DAYS SUPPLY EXCEEDED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
0348	NDC REQUIRES DIAGNOSIS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	3/5/2025	12/31/2299
0349	DIAGNOSIS REQUIRED FOR SHORT AND LONG ACTING OPIOIDS.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	7/1/2019	12/31/2299
0352	BILLED AMOUNT IS GREATER THAN CMAP ALLOWED AMOUNT. RESUBMIT WITH 340B PRICING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	3/4/2015	12/31/2299
0397	Through date of service is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0500	DATE PRESCRIBED IS AFTER THE DATE OF SUBMISSION.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0502	DATE DISPENSED IS EARLIER THAN THE DATE PRESCRIBED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0503	DATE DISPENSED IS AFTER SUBMISSION DATE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

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0505	Total other insurance/spenddown amount is > or = the billed amount.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0513	Client's name and number disagree.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0515	CHARTER OAK 120 DAY TIMELY FILING LIMIT EXCEEDED		CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0532	DISEASE STATE MANAGEMENT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0533	PDUR DRUG-ALLERGY INTERACTION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0534	PRODUR DRUG-AGE INTERACTION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0535	PDUR INGREDIENT DUPLICATION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0536	PDUR THERAPEUTIC DUPLICATION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

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0537	PDUR DRUG-TO-DRUG INTERACTION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0539	PDUR EARLY REFILL ON PRESCRIPTION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0540	PDUR MINIMUM DURATION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0541	PDUR DOSING PRECAUTION-HIGH DOSE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0542	PDUR DOSING PRECAUTION-LOW DOSE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0544	PDUR MAXIMUM DURATION OF THERAPY.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0545	CLAIM EXCEEDS TIMELY FILING LIMIT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

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0546	DRUG DISEASE MARKER.		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0547	PDUR LATE REFILL ON PRESCRIPTION.		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0551	PROVIDER ID ON ADJUSTMENT DOES NOT MATCH MOTHER		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0589	MASS ADJUSTMENT		3	CO 96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0616	ICD10 DX QUALIFIER SUBMITTED PRIOR TO EFF DATE		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0621	BILLING PROV ENTITY TYPE QUALIFIER TO PROV TYPE/SPECIALTY MISMATCH		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0631	CII QTY PRESCRIBED (460-ET) MISSING		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	9/1/2020	12/31/2299
0632	CII # OF REFILLS AUTHORIZED (415-DF) MISSING		2	CO 16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	9/1/2020	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0633	CII QTY DISPENSED GREATER THAN QTY PRESCRIBED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0634	CII QTY PRESCRIBED DOES NOT MATCH ORIGINAL QTY		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0635	CII RX DATE WRITTEN DOES NOT MATCH ORIGINAL DATE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0636	CII CUMULATIVE QTY FOR RX NUMBER > QTY PRESCRIBED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0637	CII DISP DATE > 60 DAYS FROM RX WRITTEN DATE-LTC		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0638	DISPENSE DATE FOR INCREMENTAL FILL > REG 30 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0639	CII # OF REFILLS AUTHORIZED (415-DF) > ZERO		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2020	12/31/2299
0640	CII COMPOUND QTY DISP (442-E7) MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2020	12/31/2299

Pharmacy EOB X-Ref Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0641	PROFESSIONAL SERVICE CODE MA REQUIRED	1	CO	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).	1/1/2023	12/31/2299
0643	Other Insurance indicator is missing or invalid.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0670	CLAIM TYPE NOT COVERED FOR CLIENT WITH INMATE INPATIENT HOSPITAL LOCK-IN COVERA	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0709	PHARMACY SERVICE NOT COVERED FOR HOSPICE CLIENT	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0755	CLAIM NOT PAYABLE FOR CLIENT WITH SUSPENDED MEDICAID ELIGIBILITY	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2022	12/31/2299
0775	CLAIM TYPE NOT COVERED BY COVERED CT	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	7/1/2022	12/31/2299
0776	CADAP CLAIMS PROCESSED BY MAGELLAN AS OF 11/01/2018.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	9/1/2018	12/31/2299
0777	CONNPACE BENEFIT NOT COVERED AFTER 12/31/2013	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0778	CHARTER OAK BENEFIT NOT COVERED AFTER 12/31/2013	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0788	ENOCUNTER SUBMITTED FOR INVALID CLAIM TYPE		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
0800	LOCATION CODE INVALID.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0801	QUANTITY BILLED DOES NOT EQUAL PACKAGE SIZE.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0802	PROVIDER QUALIFIER MISSING OR INVALID.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0804	PRESCRIPTION QUALIFIER IS INVALID.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0805	PRESCRIBER QUALIFIER IS INVALID.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0806	M/I OTHER PAYER ID QUALIFIER	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	9/5/2015	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0807	Diagnosis code qualifier is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0808	Other amount claimed submitted qualifier is missing or invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0809	Other insurance carrier code is missing invalid or not applicable.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0810	The other insurance amount is missing or not applicable.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0811	CONNPACE CLAIM WITH OTHER INSURANCE PAYMENT IS NOT COVERED.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0815	CLIENT'S LAST NAME IS NOT VALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0817	Client's first name is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0818	Invalid processor control number.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0819	REJECT CODE REQUIRED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0820	REJECT CODE NOT ACCEPTED FOR TPL BILLING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0825	CLIENT NAME DISAGREES WITH NAME ON FILE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0826	INVALID PROCESSOR CONTROL NUMBER. USE CTPCNPTD.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0828	INVALID PROCESSOR CONTROL NUMBER. USE CTPCNFMD.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
0829	REJECT CODE NOT ACCEPTED FOR TPL BILLING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0830	OTHER AMOUNT SUBMITTED INVALID FOR COVERAGE CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0831	MISSING/INVALID PATIENT RESIDENCE (384-4X)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0832	DATE OF BIRTH MISSING (304-C4)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0833	DATE OF BIRTH INVALID (304-C4)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0834	MISSING/INVALID PATIENT GENDER (305-C5)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0836	MISSING/INVALID PRESCRIPTION ORIGIN CODE (419-DJ)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0838	M/I PATIENT RESPONSIBILITY AMOUNT QUALIFIER (351-NP)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0845	PROVIDER NOT ALLOWED TO BILL CLAIM TYPE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0846	OTHER PAYER PATIENT RESPONSIBILITY AMOUNT INVALID FOR COVERAGE CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0847	MDD CO-PAY ONLY CLAIM WITHOUT PRIMARY BILLING INFO PLEASE CORRECT/RESUBMIT.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
0848	OCC CODE SUBMITTED WITHOUT PRIMARY PAYER INFO PLEASE CORRECT/RESUBMIT.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0849	REJECT CODE REQUIRED.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0873	MANUAL PRICE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
0881	OTHER PAYER ID QUALIFIER NOT SUPPORTED	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0882	OTHER PAYER ID QUALIFIER NOT APPLICABLE	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0883	PATIENT RESP AMOUNT QUALIFIER NOT SUPPORTED	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
0912	PROVIDER TYPE AND SPECIALTY CANNOT BE FOUND		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
0999	RECYCLE CLAIM TABLE OVERFLOW. CONTACT THE PROVIDER ASSISTANCE CENTER.					1/1/2014	12/31/2299
1000	BILLING PROVIDER IDENTIFIER IS NOT ON FILE.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

Pharmacy EOB X-Ref Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
1001	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/2/2020	12/31/2299
1003	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
1004	PROVIDER NOT ALLOWED TO BILL FROM THIS SERVICE LOCATION	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
1016	MANUFACTURER IS NOT PARTICIPATING IN DRUG REBATE ON DATE OF SERVICE DISPENSED.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
1025	OUT OF STATE PROVIDER DOES NOT HAVE A VALID LICENSE ON FILE FOR CLAIM DATES OF	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	12/1/2016	12/31/2299
1026	PRESCRIBING PROVIDER'S NPI IS NOT ON FILE.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
1801	PRESCRIBING PROV SANCTIONED BY HHS OR WITHOUT ACTIVE LICENSE ON FILE	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
1927	THE BILLING PROVIDER'S NPI IS MISSING OR INVALID.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
1945	CLAIM/DETAIL DENIED. BILLING/PERFORMING PROVIDER COULD NOT BE DETERMINED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2001	CLIENT ID IS INVALID OR NOT ON FILE. REFERENCE ID CARD FOR CORRECT NUMBER.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2002	CLIENT INELIGIBLE FOR DATES OF SERVICE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2010	CLIENT HAS NOT SATISFIED SPEND-DOWN.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2017	SERVICE IS INCLUDED IN MCO COVERAGE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2100	CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2101	CLIENT IS NOT ELIGIBLE ON ELIGIBILITY MANAGEMENT SYSTEM.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2102	CLIENT ELIGIBILITY SYSTEM IS NOT CURRENTLY AVAILABLE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
2103	UNABLE TO DETERMINE CLIENT ELIGIBILITY DUE TO INVALID CLIENT ID INVALID DATE O		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2104	CONNPACE ID IS IN AN INVALID FORMAT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2508	PHARMACY MUST BILL PRIVATE CARRIER FIRST.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2509	BILL MEDICARE FIRST.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2514	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2521	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2603	PROVIDER NOT AUTHORIZED TO BILL FOR CLIENT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2800	DATE OF SERVICE SUBMITTED IS AFTER THE CLIENT'S DATE OF DEATH.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
2801	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2802	PROGRAM REQUIRES COPAY ONLY BILLING FOR MDD.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2803	MED D COVERED DRUG - BILL MEDICARE FIRST.	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2804	Claim must be billed as crossover.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2805	Date of service submitted is prior to client's date of birth.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2806	COPAY-ONLY CLAIM > $5.00 NOT ALLOWED.		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2807	Client's date of birth is not on file. Contact DSS for eligibility corrrection.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2809	MED D NF DRUG REQUIRES PA	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
2810	ONE TIME BYPASS FILL HAS BEEN USED; EITHER MD HAS AGREED TO CHANGE TO FORMULARY	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2811	NON-FORMULARY DRUG UNDER CURRENT DSS THRESHOLD; WE ENCOURAGE PROVIDER TO CONTAC	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2812	CO-PAY ONLY CLAIM GREATER THAN $5.35 NOT ALLOWED		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2813	SAGA CLAIMS NOT COVERED PRIOR TO 02/01//08		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2814	CO-PAY ONLY CLAIM GREATER THAN $5.60 NOT ALLOWED		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2815	CHARTER OAK CLAIMS NOT COVERED PRIOR TO 08/01/2008	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
2816	CO-PAY ONLY CLAIM GREATER THAN $6.00 NOT ALLOWED		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2817	MED D NF DRUG - CONTACT MD TO INITIATE PA FROM PDP OR CHANGE TO PDP FORMULARY D	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
2818	CO-PAY ONLY CLAIM GREATER THAN $6.30 NOT ALLOWED		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2819	TB DIAGNOSIS CODE REQUIRED	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2820	CO-PAY ONLY CLAIM GREATER THAN $6.50 NOT ALLOWED		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
2821	CO-PAY ONLY CLAIM GREATER THAN $6.60 NOT ALLOWED	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2822	CO-PAY ONLY CLAIM GREATER THAN $6.35 NOT ALLOWED	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
2825	CO-PAY ONLY CLAIM GREATER THAN $7.40 NOT ALLOWED.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2016	12/31/2299
2826	CO-PAY ONLY CLAIM GREATER THAN $8.25 NOT ALLOWED.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2016	12/31/2299
2827	MEDICARE PART D CO-PAY SUBMITTED IS GREATER THAN THE ALLOWED MAXIMUM	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2018	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
2828	EM DIALYSIS DIAGNOSIS CODE REQUIRED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	8/1/2021	12/31/2299
3002	NDC REQUIRES PRIOR AUTHORIZATION		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3022	HEPATITIS C DRUG REQUIRES PA		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	10/1/2023	12/31/2299
3100	PA REQUIRED - DISPENSE THE GENERIC EQUIVALENT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3101	PA REQUIRED DISPENSE PREFERRED DRUG.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3104	PA REQ ON NDC-CALL DSS 1-800-233-2503		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3105	NON-PREFERRED MH DRUG; CONTACT MD OR GAINWELL TECHNOLOGIES FOR PA		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3106	TRANSMUCOSAL FENTANYL REQUIRES PA FOR MORE THAN FOUR (4) DOSES PER DAY		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
3107	NON-PREFERRED MH DRUG; DISPENSE PREFERRED BRAND		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3108	PA REQUIRED DISPENSE PREFERRED BRAND.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3109	PA REQUIRED FOR LONG ACTING OPIOID DRUGS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2016	12/31/2299
3110	CLAIM DENIED DAYS SUPPLY > 7		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	7/1/2019	12/31/2299
3111	CLAIM DENIED MME EXCEEDED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	7/1/2019	12/31/2299
3300	EXCEEDS MAXIMUM REFILLS ALLOWED.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3301	OPTIMAL DOSAGE EXCEEDED.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3302	THE NDC IS NOT CONSISTENT WITH THE BILLED DIAGNOSIS.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
3303	NDC IS NOT COVERED FOR THE CLIENT'S LIVING ARRANGEMENT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3304	NDC IS LESS THAN EFFECTIVE/DESI DRUG.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
3305	NO REIMBURSEMENT RULE FOR ASSOCIATED PATIENT RESIDENCE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3306	CLAIM DETAIL EXCEEDS ALLOWABLE LIMIT. CONTACT THE PROVIDER ASSISTANCE CENTER.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
3307	CLAIM NOT SUBMITTED WITH OUTER PACKAGE NDC.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
3308	DRUGS ARE INCLUDED IN THE NURSING HOME PER DIEM RATE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3309	NDC IS NOT COVERED FOR THE CLIENT'S PATIENT RESIDENCE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3314	HEADER DIAGNOSIS RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
3316	EXCEEDS THE MAXIMUM DAYS SUPPLY ALLOWED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3317	INSTITUTIONAL NDC NOT COVERED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
3318	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S GENDER		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
3319	OTC DIABETIC TESTING SUPPLIES NOT PAYABLE UNDER PHARMACY POS FOR CLIENTS OVER T		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
3330	CLAIM DETAIL EXCEEDS ALLOWABLE LIMIT. CONTACT THE PROVIDER ASSISTANCE CENTER.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4002	NDC NOT PAYABLE FOR PROGRAM.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4003	NDC EXCLUDED DRUG NOT PAYABLE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2025	12/31/2299
4004	NDC IS NOT ON FILE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
4007	NDC IS NOT COVERED DUE TO CMS TERMINATION.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4009	PRICE VARIANCE SET - VERIFY UNITS/DOLLARS.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4014	NO PRICING SEGMENT IS ON FILE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4025	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S AGE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4026	QUANTITY DISPENSED EXCEEDS MAXIMUM ALLOWED.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4040	THE PRIMARY DIAGNOSIS CODE IS INCOMPLETE OR INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4041	SECONDARY DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4044	No reimbursement rule for associated client age		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
4045	Benefit plan restriction on reimbursement agreement.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4061	NO REIMB RULE FOR ASSOCIATED CLAIM TYPE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4068	Service is not active on file on date of service.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4113	UNIT DOSE PACKAGING NOT ALLOWED FOR A CLIENT WITH THIS PATIENT LOCATION		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4127	BENEFIT PLAN HIERARCHY IS NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4130	PAYER HIERARCHY NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4131	NO BENEFIT PLAN ASSOCIATED TO PAYER. CONTACT THE PROVIDER ASSISTANCE CENTER.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4138	BILLING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER THE CLIENT'S BE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
4139	PERFORMING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER THE CLIENT'S		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4148	PERFORMING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER PROVIDER CON		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4153	NDC CODE IS UNDER MEDICAL REVIEW FOR THIS PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4160	PROVIDER CONTRACT RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4164	NDC IS INACTIVE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4165	Exceeds the allowed days supply.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4222	NDC CODE IS UNDER MEDICAL REVIEW FOR THIS BENEFIT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4250	No reimbursement rule for the associated provider type/provider specialty		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
4254	PATIENT RESIDENCE RESTRICTION FOR NDC ON PROVIDER CONTRACT	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4256	PRIMARY DIAGNOSIS RESTRICTION FOR THE NDC UNDER PROVIDER CONTRACT	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4257	SECONDARY DIAGNOSIS RESTRICTION FOR THE NDC UNDER BENEFIT PLAN	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4258	SECONDARY DIAGNOSIS RESTRICTION FOR THE NDC UNDER PROVIDER CONTRACT	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4295	PROVIDER CERTIFICATION RESTRICTION FOR BILLED NDC UNDER PROVIDER CONTRACT	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2022	12/31/2299
4296	PROVIDER CERTIFICATION RESTRICTION FOR COVERED NDC UNDER CLIENT PLAN	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2022	12/31/2299
4361	THE NDC BILLED REQUIRES A DIAGNOSIS CODE.	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4373	CLAIM TYPE RESTRICTION FOR NDC UNDER BENEFIT PLAN		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299

Pharmacy EOB X-Ref Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
4713	AGE RESTRICTION FOR THE NDC UNDER THE PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4775	BILLING PROVIDER NOT AUTHORIZED TO BILL FOR SUBMITTED NATIONAL DRUG CODE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4803	NDC IS NOT BILLABLE UNDER PROVIDER CONTRACT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4831	Service is not payable on date of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
4873	Invalid claim type for National Drug Code submitted.		CO	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023 Usage: Use this code only when a more specific Claim Adjustme	1/1/2014	12/31/2299
4960	BENEFIT PLAN RESTRICTION FOR NDC UNDER BENEFIT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4962	GENDER RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
4965	BENEFIT PLAN RESTRICTION FOR NDC UNDER PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299

Pharmacy EOB X-Ref Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
5000	POSSIBLE DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
5001	EXACT DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299
6000	SUSPENDED MANUALLY PRICED CLAIM CURRENTLY UNDER REVIEW.		1 CO	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).	9/5/2015	12/31/2299
6555	EXCEEDED ENTERAL QUANTITY.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
6556	DURATION OF THERAPY EXCEEDED.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2014	12/31/2299
6600	EXCEEDS COVID VACCINE LIMITATION		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	12/1/2020	12/31/2299
6601	COVID VACCINE LIMIT EXCEEDED NUMBER		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	12/1/2020	12/31/2299
6602	EXCEEDED COVID VACCINE LIMIT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	12/18/2020	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
6603	INSULIN LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6604	BLOOD SUGAR DIAGNOSTICS LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6605	GLUCAGON LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6606	ALCOHOL ANTISEPTIC PAD LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6607	BLOOD KETONE TEST STRIPS LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6608	NEEDLES SAFETY AND PEN NEEDLE LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6609	SYRINGES AND ACCESSORIES LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6610	DIABETIC SUPPLIES LIMITED TO 1 IN 365 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	Eff Date	End Date
6611	EXCEEDS COVID VACCINE LIMITATION		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	1/1/2021	12/31/2299
6612	EXCEEDS COVID OTC TEST LIMITATION OF 8 PER MONTH		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	12/1/2021	12/31/2299
7000	CLAIM SET AN OVERRIDEABLE PRODUR ALERT.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0000	INACTIVE ERROR CODE. MODIFIED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0001	INTERNAL EDIT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0002	PROCESSED IN ERROR. CLAIM WILL BE REPROCESSED.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N35	Program integrity/utilization review decision.	1/1/2014	12/31/2299
0003	CLAIM DENIED. FIX ERRORS AND RESUBMIT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M49	Missing/incomplete/invalid value code(s) or amount(s).	9/5/2015	12/31/2299
0009	EMS ELIGIBILITY BYPASSED		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2014	12/31/2299
0010	ANNUAL BENEFIT LIMIT EXCEEDED WITH NO PA-MASS ADJ							1/1/2018	12/31/2299
0013	COMPOSITE APC APPLIED							7/1/2016	12/31/2299
0014	COMPREHENSIVE APC APPLIED							3/13/2019	12/31/2299
0015	APC SI IND CHANGED FROM NOT PAYABLE TO PAYABLE. REFER TO ADDENDUM B- INFORMATIO							7/1/2016	12/31/2299
0016	APC SI ND CHANGED FROM NOT PAYABLE TO PAYABLE G/K. REFER TO ADDENDUM B - INFORM							7/1/2016	12/31/2299
0017	APC SI IND CHANGED FROM NOT PAYABLE TO PAYABLE H T MANUAL. REFER TO ADDENDUM B							7/1/2016	12/31/2299
0018	APC SI IND CHANGED FROM NOT PAYABLE TO CONDITIONALLY PKG. REFER TO ADDENDUM B -							7/1/2016	12/31/2299
0019	APC SI IND CHANGED FROM NOT PAYABLE TO PACKAGED. REFER TO ADDENDUM B - INFORMAT							7/1/2016	12/31/2299
0020	APC SI IND CHANGED TO CONDITIONAL MANUAL REFER TO ADDENDUM B- INFORMATIONAL ONL							7/1/2016	12/31/2299
0021	APC SI IND CHANGED TO NOT PAYABLE. REFER TO ADDENDUM B - INFORMATIONAL ONLY							7/1/2016	12/31/2299
0022	ONE TIME EARLY REFILL OVERRIDE FOR HUSKY B CLIENT WITHOUT PA HAS BEEN UTILIZED.							1/1/2018	12/31/2299
0023	APC CLAIM ADJUSTED DUE TO NEW CPT/HCPC PROCEDURE CODE							1/1/2017	12/31/2299
0026	CLAIM BYPASSED EDIT 207 DUE TO RESIDENT ENROLLED IN PAST 190 DAYS							1/1/2014	12/31/2299
0034	CLAIM BYPASSED EDIT 1035 DUE TO NPI BYPASS		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
0035	CLAIM BYPASSED EDIT 1036 DUE TO NPI BYPASS		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
0036	CLAIM BYPASSED EDIT 1033 DUE TO NPI BYPASS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N253	Missing/incomplete/invalid attending provider primary identifier.	1/1/2014	12/31/2299
0040	CLAIM PAID BEYOND TIMELY FILING LIMIT DUE TO SPECIAL HANDLING		3 CO	29	The time limit for filing has expired.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0041	UNITS ROUNDED TO WHOLE NUMBER		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			8/1/2015	12/31/2299
0042	CLAIM HAD MCLIP AID CATEGORY UPDATE							1/1/1900	12/31/2299
0043	CLAIM BYPASSED EDIT 0207 DUE TO PLAN B RX							1/1/1900	12/31/2299
0045	CLAIM BYPASSED BENEFIT PLAN HIERARCHY OVERLAP		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2014	12/31/2299
0046	CLAIM BYPASSED LAB EOB 8700 DUE TO MEDICARE ADVANTAGE PLAN		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2014	12/31/2299
0047	CONFIRMED VISIT UNITS ARE EXCEEDED	2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N820	Electronic Visit Verification System units do not meet requirements of visit.	1/2/2020	12/31/2299
0050	PROGRAM RESTRICTIONS BYPASSED DUE TO TPL.	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0051	PROGRAM RESTRICTIONS BYPASSED DUE TO CORONAVIRUS	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			3/1/2020	12/31/2299
0053	PHARMACIST EDIT 207 BYPASS TO PRESCRIBE PAXLOVID	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			6/1/2022	12/31/2299
0054	MILLIGRAM MORPHINE EQUIVALENCY (MME) IN EXCESS OF THRESHOLD OVERRIDDEN BY PHARM	3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			8/1/2016	12/31/2299
0055	CLAIM BYPASSED PRIOR AUTHORIZATION AND PRICED BEHAVIORAL HEALTH OR REHAB PER DI							3/1/2020	12/31/2299
0056	ALLIED TIMESHEET ICN. RE-SUBMIT CLAIM AGAIN ONCE TIMESHEET VALIDATED							1/1/1900	12/31/2299
0084	PARTIAL RECOUPMENT.	3	CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
0091	REDUCED TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.	3	CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
0093	WE HAVE DEDUCTED THE ORIGINAL PAYMENT AS A RESULT OF A PAYMENT APPEAL.	3	CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
0094	PAYMENT AMOUNT REDUCED BY EXCESS ASSETS.							1/1/2014	12/31/2299
0097	PAYMENT REDUCED BY OTHER INSURANCE/ADJUSTMENT TO PAYMENT AMOUNT.	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0100	REDUCE TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.	3	CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
0102	SERVICE IS NOT COVERED FOR ELIGIBILITY DETERMINATION.							1/1/2014	12/31/2299
0107	PAID AMOUNT REDUCED BY OTHER INSURANCE AND COPAY.	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0108	PAID AMOUNT REDUCED TO ZERO BY OTHER INSURANCE AND COPAY.	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0109	AMOUNT REFLECTS MONIES RECOUPED FOR MEDICARE COVERED SERVICES.	3	CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0111	MEDICARE RECONSIDERATION ADJUSTMENT.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0113	CLAIM/DETAIL PAID USING FQHC PRICING.		3 CO	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.	1/1/2014	12/31/2299
0131	PAYMENT AMOUNT REFLECTS COMPOSITE PANEL RATE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
0135	DENIED. CLAIM CORRECTION FORM RESPONSE NOT RECEIVED OR INSUFFICIENT TO PROCESS.		3 CO	272	Coverage/program guidelines were not met.			5/1/2016	12/31/2299
0137	HMS SPECIAL PROJECT RECOUPMENT-FULL.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299
0158	CLAIM/DETAIL PAID PARTIAL CO-INSURANCE AND DEDUCTIBLE BILLED.		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0159	CLAIM/DETAIL PAID PARTIAL DEDUCTIBLE BILLED.		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0161	CLAIM DETAIL DENIED OR SERVICE INCLUDED IN PAYMENT / ALLOWANCE ALREADY ADJUDICA		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0164	CLAIM/DETAIL PAID IN FULL BY MEDICARE.		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0165	MEDICARE PAYMENT IS EQUAL TO OR EXCEEDS MEDICAID ALLOWED CHARGE.		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0169	NO CO-INSURANCE OR DEDUCTIBLE DUE.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0171	PAYMENT AMOUNT REDUCED BY APPLIED INCOME.							1/1/2014	12/31/2299
0177	PAYMENT AMOUNT REFLECTS RENT TO PURCHASE PRICING.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
0188	THIS SAGA CLAIM HAS BEEN RECOUPED AND RESUBMITTED AS A MEDICAID CLAIM.							1/1/2014	12/31/2299
0195	RETROACTIVE DATE		2 CO	13	The date of death precedes the date of service.			1/1/2014	12/31/2299
0201	Billing provider identifier is missing.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
0202	Billing provider identifier is invalid.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
0203	Client identification number is missing.		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
0208	PREGNANCY INDICATOR INVALID							1/1/2014	12/31/2299
0217	GENERIC RETROACTIVE ME ADJUSTMENT.							1/1/2014	12/31/2299
0223	Required ICD-9-CM diagnosis code is missing or invalid.							1/1/2014	12/31/2299
0224	Detail diagnosis code pointer invalid on paper claim.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0225	PATIENT LIABILITY ADJUSTMENT.		PR	142	Claim adjusted by the monthly Medicaid patient liability amount.			1/1/2014	12/31/2299
0226	Referring provider name/number is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N286	Missing/incomplete/invalid referring provider primary identifier.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0227	OTHER PAYER PAYMENT AMOUNT IS INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N58	Missing/incomplete/invalid patient liability amount.	1/1/2014	12/31/2299
0229	The source of admission is missing or invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA42	Missing/incomplete/invalid admission source.	1/1/2014	12/31/2299
0231	Performing provider is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N290	Missing/incomplete/invalid rendering provider primary identifier.	1/1/2014	12/31/2299
0232	RATE CHANGE ADJUSTMENT.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
0233	Number of days visits or units of service is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
0234	PROCEDURE CODE IS MISSING OR INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0235	PROCEDURE CODE NOT IN VALID FORMAT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0238	Client's last name is missing.		2 CO	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.	1/1/2014	12/31/2299
0239	The submitted claim detail through date of service is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M59	Missing/incomplete/invalid to date(s) of service.	1/1/2014	12/31/2299
0240	The submitted claim detail through date of service is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M59	Missing/incomplete/invalid to date(s) of service.	1/1/2014	12/31/2299
0241	Accident code is invalid.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
0242	Secondary diagnosis code submitted in an invalid format.							1/1/2014	12/31/2299
0244	Third diagnosis code submitted in an invalid format.							1/1/2014	12/31/2299
0246	Fourth diagnosis code submitted in an invalid format.							1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0247	Exceeds maximum number of claim details allowed.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N61	Rebill services on separate claims.	1/1/2014	12/31/2299
0248	Facility type code is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M77	Missing/incomplete/invalid/inappropriate place of serivce.	1/1/2014	12/31/2299
0249	Facility type code is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M77	Missing/incomplete/invalid/inappropriate place of serivce.	1/1/2014	12/31/2299
0250	Claim submitted without any services billed.		2 CO	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2014	12/31/2299
0251	FIRST MODIFIER IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N823	Incomplete/Invalid procedure modifier(s).	1/2/2020	12/31/2299
0252	SECOND MODIFIER IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N823	Incomplete/Invalid procedure modifier(s).	1/2/2020	12/31/2299
0253	THIRD MODIFIER IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N823	Incomplete/Invalid procedure modifier(s).	1/2/2020	12/31/2299
0254	PRESCRIBING PROVIDER PRIMARY NPPES TAXONOMY NOT AUTHORIZED TO PRESCRIBE							1/1/2014	12/31/2299
0258	Primary diagnosis code is missing or invalid		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA63	Missing/incomplete/invalid principal diagnosis.	1/1/2014	12/31/2299
0260	UNITS OF SERVICE IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0261	Tooth number is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N37	Missing/incomplete/invalid tooth number/letter.	1/1/2014	12/31/2299
0262	Tooth number is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N37	Missing/incomplete/invalid tooth number/letter.	1/1/2014	12/31/2299
0263	Tooth surface is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N75	Missing/incomplete/invalid tooth surface information.	1/1/2014	12/31/2299
0264	DETAIL DATE OF SERVICE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299
0265	DETAIL DATE OF SERVICE IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299
0266	INCORRECT NUMBER OF TOOTH SURFACE CODES BILLED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N75	Missing/incomplete/invalid tooth surface information.	1/1/2014	12/31/2299
0268	DETAIL BILLED AMOUNT IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
0269	DETAIL BILLED AMOUNT IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
0270	TOTAL CHARGE IS MISSING OR ZERO.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M54	Missing/incomplete/invalid total charges.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0271	TOTAL CHARGE IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M54	Missing/incomplete/invalid total charges.	1/1/2014	12/31/2299
0272	PRIMARY DIAGNOSIS CODE INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA63	Missing/incomplete/invalid principal diagnosis.	1/1/2014	12/31/2299
0273	Type of bill is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA30	Missing/incomplete/invalid type of bill.	1/1/2014	12/31/2299
0274	Type of bill is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA30	Missing/incomplete/invalid type of bill.	1/1/2014	12/31/2299
0275	Admission date is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA40	Missing/incomplete/invalid admission date.	1/1/2014	12/31/2299
0276	Admission date is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA40	Missing/incomplete/invalid admission date.	1/1/2014	12/31/2299
0277	Admission hour is missing or invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N46	Missing/incomplete/invalid admission hour.	1/1/2014	12/31/2299
0278	Admission type is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA41	Missing/incomplete/invalid admission type.	1/1/2014	12/31/2299
0279	Admission type is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA41	Missing/incomplete/invalid admission type.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0280	Patient status is missing.		2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA43	Missing/incomplete/invalid patient status.	1/1/2014	12/31/2299
0281	Patient status is invalid.		2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA43	Missing/incomplete/invalid patient status.	1/1/2014	12/31/2299
0303	APC -INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE		2	CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	7/1/2016	12/31/2299
0304	APC -SERVICE CONSIDERED AN INPATIENT PROCEDURE		3	CO	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M77	Missing/incomplete/invalid/inappropriate place of serivce.	7/1/2016	12/31/2299
0305	APC -MEDICAL VISIT ON SAME DAY AS TYPE T OR S PROC W/O MODIFIER-25 SIGNIFICANT		2	CO	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0306	APC -MEDICAL VISIT ON SAME DAY AS TYPE T OR S PROC		3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
0307	APC-INVALID AGE		3	CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	7/1/2016	12/31/2299
0308	APC-INVALID GENDER		3	CO	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299
0309	APC-ONLY INCIDENTAL SERVICES REPORTED		4	CO	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.	9/10/2016	12/31/2299
0310	APC-STATUS INDICATOR NOT FOUND		3	CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
0311	APC -IMPLANTED DEVICE W/O IMPLANTATION PROCEDURE OR ADMINISTERED SUBSTANCE W/O		3	CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	9/10/2016	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0312	MULTIPLE MEDICAL VISITS WITH SAME RCC AND SAME DAY REQUIRE CONDITION CODE G0		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	7/1/2016	12/31/2299
0313	APC-TRANSFUSION OR BLOOD PRODUCT EXCHANGE WITHOUT SPECIFICATION OF BLOOD PRODUC		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	4/18/2016	12/31/2299
0314	APC-OBSERVATION REVENUE CODE ON LINE ITEM WITH NON-OBSERVATION HCPCS CODE		2 CO	199	Revenue code and Procedure code do not match. 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	N657	This should be billed with the appropriate code for these services.	9/10/2016	12/31/2299
0315	APC-INPATIENT SEPARATE PROCEDURES NOT PAID WHEN ACCOMPANIED BY ANOTHER TYPE T P		4 CO	234	not an ALERT.)	N20	Service not payable with other service rendered on the same date.	7/1/2016	12/31/2299
0316	APC-INCIDENTAL PROCEDURE NOT SEPARATELY REIMBURSED		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N19	Procedure code incidental to primary procedure.	7/1/2016	12/31/2299
0317	APC-SERVICE PROVIDED SAME DAY AS AN INPATIENT PROCEDURE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
0318	APC-COMPOSITE E/M CONDITION NOT MET FOR OBSERVATION AND LINE ITEM DATE FOR CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0319	APC-G0379 ONLY ALLOWED WITH G0378		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M20	Missing/incomplete/invalid HCPCS.	7/1/2016	12/31/2299
0320	APC-MODIFIER CA ALLOWED WITH JUST ONE INPATIENT PROCEDURE PER DAY		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N519	Invalid combination of HCPCS modifiers.	7/1/2016	12/31/2299
0321	APC-CORNEAL TISSUE PROCESSING REPORTED WITHOUT CORNEA TRANSPLANT PROCEDURE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0322	APC-SERVICE PROVIDED PRIOR TO FDA APPROVAL		3 CO	188	This product/procedure is only covered when used according to FDA recommendations.			7/1/2016	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0323	APC-SERVICE PROVIDED PRIOR TO DATE OF NATIONAL COVERAGE DETERMINATION (NCD) APP		3 CO	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: 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 reque	9/10/2016	12/31/2299
0324	APC-THE SERVICE WAS PROVIDED OUTSIDE THE PERIOD APPROVED BY CMS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	7/1/2016	12/31/2299
0325	APC-CA MODIFIER REQUIRES PATIENT STATUS CODE 20 (EXPIRED)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA43	Missing/incomplete/invalid patient status.	7/1/2016	12/31/2299
0326	APC - SERVICE SUBMITTED FOR DENIAL (CONDITION CODE 21)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	7/1/2016	12/31/2299
0327	APC-INCORRECT BILLING OF BLOOD AND BLOOD PRODUCTS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0328	APC-UNITS OF SERVICE GREATER THAN 1 INAPPROPRIATE FOR BILATERAL PROCEDURE REPOR		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N430	Procedure code is inconsistent with the units billed.	7/1/2016	12/31/2299
0329	APC-TRAUMA RESPONSE CRITICAL CARE CODE WITHOUT REVENUE CODE 068X AND CPT 99291		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0332	APC-INCORRECT BILLING OF REVENUE CODE WITH HCPCS CODE		2 CO	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	9/10/2016	12/31/2299
0333	APC-CLAIM LACKS REQUIRED PRIMARY CODE		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	9/10/2016	12/31/2299
0334	APC - BLANK STATUS INDICATOR		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re			7/1/2016	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0335	APC - REDUCED/DISCONTINUED PROCEDURES ARE NOT PAYABLE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
0336	APC - CLAIM CANNOT EXCEED 450 DETAILS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N142	The original claim was denied. Resubmit a new claim not a replacement claim.	7/1/2016	12/31/2299
0337	APC - TOTAL ALLOWED AMOUNT ON APC CLAIM IS ZERO		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M54	Missing/incomplete/invalid total charges.	7/1/2016	12/31/2299
0338	APC - SERVICE MUST BE BILLED WITH PROCEDURE CODE		2 CO	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0339	Revenue center code is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M50	Missing/incomplete/invalid revenue code(s).	1/1/2014	12/31/2299
0340	Revenue center code is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M50	Missing/incomplete/invalid revenue code(s).	1/1/2014	12/31/2299
0350	Submitted number of details not equal to header submitted detail count field.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N142	The original claim was denied. Resubmit a new claim not a replacement claim.	9/5/2015	12/31/2299
0360	ADMITTING DIAGNOSIS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA65	Missing/incomplete/invalid admitting diagnosis.	1/1/2014	12/31/2299
0361	ADMITTING DIAGNOSIS CODE INVALID.							1/1/2014	12/31/2299
0363	PRINCIPAL PROCEDURE CODE INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0364	SURGICAL PROCEDURE CODE REQUIRED WHEN OPERATING PHYSICIAN IS PRESENT.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA66	Missing/incomplete/invalid principal procedure code.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0365	PRINCIPAL PROCEDURE DATE IS INVALID OR PRINCIPAL PROCEDURE CODE IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N303	Missing/incomplete/invalid principal procedure date.	1/1/2014	12/31/2299
0366	FIRST OTHER PROCEDURE CODE INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0367	SECOND PROCEDURE CODE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M67	Missing/incomplete/invalid other procedure code(s).	1/1/2014	12/31/2299
0368	Second procedure date is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0369	SECOND OTHER PROCEDURE CODE INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0370	THIRD PROCEDURE CODE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M67	Missing/incomplete/invalid other procedure code(s).	1/1/2014	12/31/2299
0371	Third procedure date is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0372	The fourth surgical procedure code is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0373	THE FOURTH SURGICAL PROCEDURE CODE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M67	Missing/incomplete/invalid other procedure code(s).	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0375	The fifth surgical procedure code is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0376	THE FIFTH SURGICAL PROCEDURE CODE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M67	Missing/incomplete/invalid other procedure code(s).	1/1/2014	12/31/2299
0379	FIFTH OTHER PROCEDURE MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M67	Missing/incomplete/invalid other procedure code(s).	1/1/2014	12/31/2299
0381	Attending provider number is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N253	Missing/incomplete/invalid attending provider primary identifier.	1/1/2014	12/31/2299
0389	Required procedure code is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M20	Missing/incomplete/invalid HCPCS.	1/1/2014	12/31/2299
0390	REVENUE CENTER CODE REQUIRES A HCPC/PROCEDURE CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0391	REVENUE CENTER CODE REQUIRES A HCPC/PROCEDURE CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0392	REVENUE CENTER CODE REQUIRES A HCPC/PROCEDURE CODE							1/1/2014	12/31/2299
0395	The from date of service is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299
0396	The from date of service is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0397	Through date of service is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M59	Missing/incomplete/invalid to date(s) of service.	1/1/2014	12/31/2299
0398	Through date of service is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M59	Missing/incomplete/invalid to date(s) of service.	1/1/2014	12/31/2299
0400	DETAIL UNITS MUST BE GREATER THAN ZERO.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
0401	The net charge is missing or invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M54	Missing/incomplete/invalid total charges.	1/1/2014	12/31/2299
0433	MEDICARE DEDUCTIBLE AMOUNT INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
0434	MEDICARE COINSURANCE AMOUNT INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
0436	TOTAL MEDICARE ALLOWED AMOUNT INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
0440	PRINCIPAL PROCEDURE DATE IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N303	Missing/incomplete/invalid principal procedure date.	1/1/2014	12/31/2299
0441	SECOND PROCEDURE DATE IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0442	SECOND OTHER PROCEDURE DATE IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0443	THIRD OTHER PROCEDURE DATE MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0444	FOURTH OTHER PROCEDURE DATE MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0445	FIFTH OTHER PROCEDURE DATE IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0446	ICD-9 PROCEDURE 7-24 DATE IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N302	Missing/incomplete/invalid other procedure date(s).	1/1/2014	12/31/2299
0450	Invalid area of oral cavity billed.							1/1/2014	12/31/2299
0451	No Medicare coinsurance or deductible billed.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
0454	Benefits assignment code is invalid. Contact the Provider Assistance Center.							1/1/2014	12/31/2299
0457	INVALID SURGICAL PROCEDURE CODE QUALIFIER SUBMITTED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	1/1/2014	12/31/2299
0458	DIAGNOSIS CODE 10 - 24 IS INCOMPLETE OF INVALID		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	10/1/2015	12/31/2299
0459	Detail diagnosis code pointer invalid on electronic claim.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0473	ICD PROCEDURE 7-24 INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	10/1/2015	12/31/2299
0474	ICD-9 PROCEDURE 7-24 MISSING							1/1/2014	12/31/2299
0485	DIAGNOSIS CODES MUST BE ALL SAME CODE SET							1/1/2014	12/31/2299
0486	ICD SURGICAL PROCEDURE CODE MUST BE SAME CODE SET		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0487	ICD DX AND SURGICAL PROCEDURE MUST BE SAME CODE SET							1/1/2014	12/31/2299
0488	ICD SURGICAL PROCEDURE NOT ALLOWED ON OUTPATIENT CLAIM		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0490	ICD10 SURGICAL QUALIFIER BEFORE EFFECTIVE DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0491	ICD9 SURGICAL CODE QUALIFIER SUBMITTED AFTER EFFECTIVE DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0492	ICD9 DIAGNOSIS CODE QUALIFIERS AFTER ICD10 IMPLEMENTATION DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0507	The through date of service is before the from date of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299
0508	Total charges do not equal the sum of all detail charges.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M54	Missing/incomplete/invalid total charges.	1/1/2014	12/31/2299
0509	THE NET CHARGE IS OUT OF BALANCE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
0512	CLAIM EXCEEDS TIMELY FILING LIMIT.		3 CO	29	The time limit for filing has expired.			1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0513	Client's name and number disagree.		2 CO	140	Patient/Insured health identification number and name do not match.			1/1/2014	12/31/2299
0514	The through date of service contains a future date.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M59	Missing/incomplete/invalid to date(s) of service.	1/1/2014	12/31/2299
0515	CHARTER OAK 120 DAY TIMELY FILING LIMIT EXCEEDED							1/1/2014	12/31/2299
0516	CLAIM IS PAST 180 DAY FQHC TIMELY FILING LIMIT.		3 CO	29	The time limit for filing has expired.			1/1/2014	12/31/2299
0518	Total accommodation days billed are not equal to the elapsed days.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA32	Missing/incomplete/invalid number of covered days during the billing period.	1/1/2014	12/31/2299
0519	Admission date is after the from date of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA40	Missing/incomplete/invalid admission date.	1/1/2014	12/31/2299
0521	The through date of service is after the discharge date.							1/1/2014	12/31/2299
0526	The from date of service is illogical.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299
0527	Detail from date of service is after date of submission.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M52	Missing/incomplete/invalid from date(s) of service.	1/1/2014	12/31/2299
0529	Surgical procedure date is prior to admission date.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N341	Missing/incomplete/invalid surgery date.	1/1/2014	12/31/2299
0530	Surgical procedure date is after patient discharge date.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N341	Missing/incomplete/invalid surgery date.	1/1/2014	12/31/2299
0538	MODIFIER REQUIRED FOR PROVIDER TYPE AND SPECIALTY		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: 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.	9/1/2020	12/31/2299
0550	ELECTRONIC ADJUSTMENT IS INVALID.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
0551	PROVIDER ID ON ADJUSTMENT DOES NOT MATCH MOTHER		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N152	Missing/incomplete/invalid replacement claim information.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0552	CLIENT ID ON ADJUSTMENT DOES NOT MATCH MOTHER		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N152	Missing/incomplete/invalid replacement claim information.	1/1/2014	12/31/2299
0555	Claim is past Behavioral Health timely filing guidelines.		3 CO	29	The time limit for filing has expired.			1/1/2014	12/31/2299
0557	NH LEAVE OF ABSENCE REQUIRES OCCURRENCE DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N299	Missing/incomplete/invalid occurrence date(s).	1/1/2014	12/31/2299
0559	Medicare coinsurance amount is greater than the Medicare paid amount.							1/1/2014	12/31/2299
0560	MODIFIER NOT ALLOWED TO BE BILLED WITH PROCEDURE		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N519	Invalid combination of HCPCS modifiers.	1/1/2016	12/31/2299
0561	PROVIDER TYPE AND SPECIALTY NOT ALLOWED TO BILL MODIFIER		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2016	12/31/2299
0562	REFERRING PROVIDER TYPE AND SPECIALTY NOT VALID FOR BILLING PROVIDER		3 CO	183	The referring provider is not eligible to refer the service billed. Usage: 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.	8/1/2019	12/31/2299
0563	ORDERING PROVIDER TYPE AND SPECIALTY NOT VALID FOR BILLING PROVIDER		3 CO	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: 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.	8/1/2019	12/31/2299
0564	RENDERING PROVIDER TYPE AND SPECIALTY NOT VALID FOR BILLING PROVIDER		3 CO	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N808	Not covered for this provider type / provider.	8/1/2019	12/31/2299
0568	The admission date is after the discharge date.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N50	Missing/incomplete/invalid discharge information.	1/1/2014	12/31/2299
0570	HEADER TOTAL DAYS LESS THAN COVERED DAYS.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA32	Missing/incomplete/invalid number of covered days during the billing period.	1/1/2014	12/31/2299
0571	Primary surgical procedure required when surgical RCC is billed.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M20	Missing/incomplete/invalid HCPCS.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0572	Quantity disagrees with days elapsed.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0574	Dates of service cannot span calendar months.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0575	Primary or secondary surgical date is outside of the claims dates of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N341	Missing/incomplete/invalid surgery date.	1/1/2014	12/31/2299
0580	DETAIL DATES ARE NOT IN THE SAME MONTH-HEADER OR DETAIL		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1/1/2014	12/31/2299
0589	MASS ADJUSTMENT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N35	Program integrity/utilization review decision.	1/1/2014	12/31/2299
0592	CLAIM EXCEEDS TIMELY FILING LIMIT.							1/1/2014	12/31/2299
0600	The number of quadrants billed does not equal the number of units billed.							1/1/2014	12/31/2299
0601	ONLY QUADRANT NOT TOOTH NUMBER ALLOWED FOR THIS PROCEDURE CODE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N37	Missing/incomplete/invalid tooth number/letter.	1/1/2014	12/31/2299
0604	ONLY 1 QUADRANT ALLOWED PER CLAIM DETAIL		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N37	Missing/incomplete/invalid tooth number/letter.	1/1/2014	12/31/2299
0608	COMPOSITES NOT COVERED FOR CLIENTS 21 OR OLDER FOR FIRST OR SECOND MOLAR TEETH.		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
0610	TOOTH NUMBER/TOOTH SURFACE COMBINATION INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N75	Missing/incomplete/invalid tooth surface information.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0611	SURFACE B & F NOT PAYABLE TOGETHER - EQUAL SURFACES		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N75	Missing/incomplete/invalid tooth surface information.	1/1/2014	12/31/2299
0612	TOOTH NUMBER/ARCH COMBO INVALID. WEB QUADRANT FIELD 01 OR 02 REPRESENT THE ARE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N37	Missing/incomplete/invalid tooth number/letter.	11/1/2022	12/31/2299
0615	PATIENT REASON FOR VISIT INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0616	ICD10 DX QUALIFIER SUBMITTED PRIOR TO EFF DATE		2 CO	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
0617	INVALID CLAIM VERSION - SUBMIT IN NEW HIPAA 5010		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
0618	BILLING PROVIDER ADDRESS CANNOT CONTAIN PO BOX		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N258	Missing/incomplete/invalid billing provider/supplier address.	1/1/2014	12/31/2299
0619	ZIP CODE IS NOT A VALID 9 DIGIT ZIP CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N258	Missing/incomplete/invalid billing provider/supplier address.	1/1/2014	12/31/2299
0620	SERVICE FACILITY ZIP CODE IS INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N258	Missing/incomplete/invalid billing provider/supplier address.	1/1/2014	12/31/2299
0621	BILLING PROV ENTITY TYPE QUALIFIER TO PROV TYPE/SPECIALTY MISMATCH		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N77	Missing/incomplete/invalid designated provider number.	1/1/2014	12/31/2299
0622	RENDERING PROVIDER TYPE/SPECIALTY CONFLICT WITH ENTITY TYPE QUALIFIER		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N32	Claim must be submitted by the provider who rendered the service.	1/1/2014	12/31/2299
0626	ABC DENTAL CERTIFICATION MISSING OR NOT ACTIVE ON CLAIM DATES OF SERVICE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N54	Claim information is inconsistent with pre-certified/authorized services.	7/1/2019	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0630	CLAIM MUST BE SUBMITTED VIA EVV SYSTEM		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2017	12/31/2299
0660	UNIT OF MEASURE SUBMITTED ON THE CLAIM IS NOT CONSISTENT WITH THE DRUG UNIT FOR		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	7/1/2016	12/31/2299
0661	CLAIM NDC QUANTITY EXCEEDS THE MAXIMUM QUANTITY DEFINED FOR HCPC DRUG FEE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N378	Missing/incomplete/invalid prescription quantity.	7/1/2016	12/31/2299
0670	CLAIM TYPE NOT COVERED FOR CLIENT WITH INMATE INPATIENT HOSPITAL LOCK-IN COVERA		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0671	DRG COVERED/NON-COVERED DAYS DISAGREE WITH THE STATEMENT PERIOD		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA32	Missing/incomplete/invalid number of covered days during the billing period.	1/1/2014	12/31/2299
0672	DRG ACCOMMODATION DAYS INCONSISTENT WITH THE HEADER DATE PERIOD		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA32	Missing/incomplete/invalid number of covered days during the billing period.	1/1/2014	12/31/2299
0674	DRG INTERIM CLAIMS NOT ALLOWED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	12/24/2014	12/31/2299
0675	PROVIDER DRG RATE NOT FOUND		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	12/24/2014	12/31/2299
0676	DRG CODE WEIGHT NOT FOUND		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	12/24/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0679	OUTLIER THRESHOLD NOT FOUND		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	12/24/2014	12/31/2299
0680	OUTLIER PERCENT NOT FOUND		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	12/24/2014	12/31/2299
0681	DRG CODE NOT FOUND IN OUR SYSTEM		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N208	Missing/incomplete/invalid DRG code	12/24/2014	12/31/2299
0682	INVALID DISCHARGE STATUS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N50	Missing/incomplete/invalid discharge information.	1/1/2015	12/31/2299
0683	DRG IS UNGROUPABLE DUE TO DIAGNOSIS AND CLIENT'S GENDER MISMATCH		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA39	Missing/incomplete/invalid gender.	1/1/2015	12/31/2299
0684	INVALID AGE IN YEARS OR ADMISSION AGE IN DAYS		3 CO	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/5/2015	12/31/2299
0685	UNGROUPABLE DUE TO UNACCEPTABLE PRINCIPAL DIAGNOSIS (V CODE)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA63	Missing/incomplete/invalid principal diagnosis.	1/1/2015	12/31/2299
0686	EDIT UNGROUPABLE DUE TO SECONDARY DIAGNOSIS REQUIRED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M64	Missing/incomplete/invalid other diagnosis.	1/1/2015	12/31/2299
0687	UNGROUPABLE DUE TO AGE CONFLICT WITH PRINCIPAL DIAGNOSIS		3 CO	9	The diagnosis is inconsistent with the patient's age. Usage: 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.	9/5/2015	12/31/2299
0688	UNGROUPABLE DUE TO SEX CONFLICT WITH PRINCIPAL DIAGNOSIS		3 CO	10	The diagnosis is inconsistent with the patient's gender. Usage: 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.	9/4/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0689	DIAGNOSIS CODE CANNOT BE USED AS PRINCIPAL DIAGNOSIS (E-CODES)		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA63	Missing/incomplete/invalid principal diagnosis.	1/1/2015	12/31/2299
0690	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	12/24/2014	12/31/2299
0692	EDIT INVALID BIRTH WEIGHT OR AGE/BIRTH WEIGHT CONFLICT		2 CO	240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N207	Missing/incomplete/invalid weight.	1/1/2015	12/31/2299
0693	INVALID PRINCIPAL DIAGNOSIS		2 CO	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	MA65	Missing/incomplete/invalid admitting diagnosis.	1/1/2015	12/31/2299
0694	APC CODE NOT FOUND		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0695	APC WEIGHT NOT FOUND		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0696	APC OUTLIER THRESHOLD PERCENTAGE NOT FOUND.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0697	APC OUTLIER THRESHOLD MULTIPLIER NOT FOUND		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0698	APC PROVIDER WAGE ADJUSTED CONVERSION FACTOR NOT FOUND		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0699	APC OUTLIER THRESHOLD AMOUNT NOT FOUND.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N657	This should be billed with the appropriate code for these services.	7/1/2016	12/31/2299
0700	RESPITE OR CONTINUOUS CARE NOT ALLOWED FOR CLIENTS IN A NURSING FACILITY		3 CO	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.	1/1/2014	12/31/2299
0701	HOSPICE ROOM AND BOARD NOT COVERED FOR ICF/MR PROVIDER TYPE AND SPECIALTY.		3 CO	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.	1/1/2014	12/31/2299
0702	HOSPICE ROOM AND BOARD NOT COVERED WITHOUT NURSING HOME AUTHORIZATION.		3 CO	B9	Services not covered because the patient is enrolled in a Hospice.			1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0703	HOSPICE REQUIRED HOURS NOT MET		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
0704	RCC NOT ALLOWED FOR HOSPICE CLIENT		3 CO	B9	Services not covered because the patient is enrolled in a Hospice.			1/1/2014	12/31/2299
0705	OUTPATIENT CLAIM FOR HOSPICE CLIENT REQUIRES CONDITION CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	1/1/2014	12/31/2299
0706	SERVICE NOT COVERED FOR HOSPICE CLIENT		3 CO	B9	Services not covered because the patient is enrolled in a Hospice.			1/1/2014	12/31/2299
0707	HOSPICE RADIOLOGY SERVICES REQUIRE MODIFIER		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N519	Invalid combination of HCPCS modifiers.	1/1/2014	12/31/2299
0708	CROSOVER NOT COVERED FOR HOSPICE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
0710	REVENUE NOT COVERED FOR CLIENT ENROLLED IN MEDICARE HOSPICE.		3 CO	B9	Services not covered because the patient is enrolled in a Hospice.			1/1/2014	12/31/2299
0711	CLAIM DENIED. CLIENT DOES NOT HAVE HOSPICE LOCK-IN.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N143	The patient was not in a hospice program during all or part of the service dates billed.	1/1/2014	12/31/2299
0715	CLAIM TYPE NOT PAYABLE FOR PROVIDER TYPE AND SPECIALTY		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N34	Incorrect claim form/format for this service.	1/1/2014	12/31/2299
0716	CLAIM TYPE NOT PAYABLE FOR PROVIDER TYPE AND SPECIALTY		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N34	Incorrect claim form/format for this service.	1/1/2014	12/31/2299
0719	CONDITION CODE G0 REQUIRED WHEN USING MODIFIER 27 TO IDENTIFY A DISTINCT/SEPARA		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	7/1/2015	12/31/2299
0720	MODIFIER NOT COVERED - OTHER PROVIDER PREVENTABLE CONDITIONS		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0721	DIAGNOSIS NOT COVERED - OTHER PROVIDER PREVENTABLE CONDITIONS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N569	Not covered when performed for the reported diagnosis.	1/1/2014	12/31/2299
0722	OCCURRENCE CODE 55 REQUIRED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M45	Missing/incomplete/invalid occurrence code(s).	1/1/2016	12/31/2299
0723	OCCURRENCE CODE 55 MISSING DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M45	Missing/incomplete/invalid occurrence code(s).	1/1/2016	12/31/2299
0724	OCCURRENCE CODE 55 INVALID DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M45	Missing/incomplete/invalid occurrence code(s).	1/1/2016	12/31/2299
0725	DATE OF DEATH NOT WITHIN 7 DAYS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			3/21/2016	12/31/2299
0730	NEMT BROKER TP ID IS NOT PRESENT ON NON-EMERGENCY TRANSPORTATION CLAIM		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: 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.	1/1/2014	12/31/2299
0731	NEMT CLAIMS IS BILLED FOR OUT OF STATE PROVIDER		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: 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.	1/1/2014	12/31/2299
0740	PROCEDURE NOT PAYABLE FOR CROSSOVER CLAIM		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	3/1/2020	12/31/2299
0744	OTHER PROVIDER QUALIFIER INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N77	Missing/incomplete/invalid designated provider number.	1/1/2014	12/31/2299
0747	MODIFIER SA OR SB REQUIRED FOR PERFORMING PT/PS		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: 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.	9/1/2020	12/31/2299
0749	MODIFIER U2 NOT ALLOWED		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: 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.	9/1/2020	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0750	CHC PROCEDURE NOT BILLABLE WITH OTHER PROCEDURES		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: 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.	1/1/2014	12/31/2299
0751	BIRTH WEIGHT REQUIRED WITH ADMIT TYPE OF '4' (NEWBORN)		2 CO	240	The diagnosis is inconsistent with the patient's birth weight. Usage: 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.	1/1/2014	12/31/2299
0752	PRESENT ON ADMISSION INDICATOR MISSING OR INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N434	Missing/Incomplete/Invalid Present on Admission indicator.	1/1/2014	12/31/2299
0755	CLAIM NOT PAYABLE FOR CLIENT WITH SUSPENDED MEDICAID ELIGIBILITY		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2022	12/31/2299
0760	CONDITION CODE RESTRICTION FOR BILLED PROCEDURE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	1/1/2014	12/31/2299
0770	MUE UNITS EXCEEDED		3 CO	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: 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.	1/1/2014	12/31/2299
0771	UNIT OF SERVICE > MUE DENIED OTHER EDIT		3 CO	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: 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.	7/1/2016	12/31/2299
0772	UNIT OF SERVICE > MUE AND CLAIM PAID/DENIED AFTER POLICY REVIEW		3 CO	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: 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.	7/1/2016	12/31/2299
0775	CLAIM TYPE NOT COVERED BY COVERED CT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2022	12/31/2299
0778	CHARTER OAK BENEFIT NOT COVERED AFTER 12/31/2013		3 CO	166	These services were submitted after this payers responsibility for processing claims under this plan ended.			1/1/2014	12/31/2299
0779	ENCOUNTER CLAIMS NOT PAYABLE FOR DATES OF SERVICE AFTER 12/31/2011.							1/1/2014	12/31/2299
0780	PRICED AT ENCOUNTER PAID AMOUNT							1/1/2014	12/31/2299
0781	DATE OF SERVICE PRIOR TO GAINWELL TECHNOLOGIES ENCOUNTER SUBMISSION.							1/1/2014	12/31/2299
0782	NETWORK BILLING PROVIDER REQUIRED FOR ENCOUNTER.							1/1/2014	12/31/2299
0783	NETWORK PERFORMING PROVIDER REQUIRED FOR ENCOUNTER.							1/1/2014	12/31/2299
0784	INVALID ENCOUNTER ADJUSTMENT							1/1/2014	12/31/2299
0785	OTHER PAYER ID INCONSISTENT WITH SUBMITTER.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M56	Missing/incomplete/invalid payer identifier.	1/1/2014	12/31/2299
0786	INVALID SUBMITTER ID FOR ENCOUNTER.							1/1/2014	12/31/2299
0788	ENOCUNTER SUBMITTED FOR INVALID CLAIM TYPE							1/1/2014	12/31/2299
0789	ENCOUNTER OTHER PAYER ICN IS MISSING							1/1/2014	12/31/2299
0790	ENCOUNTER DENIED DETAIL							1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0791	ZERO PAID ENCOUNTER CLAIM							1/1/2014	12/31/2299
0792	SUSPECT PROVIDER MATCH							1/1/2014	12/31/2299
0803	THE PATIENT CONTROL NUMBER IS MISSING.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N382	Missing/incomplete/invalid patient identifier.	1/1/2014	12/31/2299
0812	Patient status is not billable for the Connecticut Medical Assistance Program.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA43	Missing/incomplete/invalid patient status.	1/1/2014	12/31/2299
0813	Claim denied after Medical Policy review.		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	1/1/2014	12/31/2299
0814	CLAIM DENIED FOR MEDICAL POLICY REVIEW.		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	1/1/2014	12/31/2299
0815	CLIENT'S LAST NAME IS NOT VALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA36	Missing/incomplete/invalid patient name.	1/1/2014	12/31/2299
0816	CLIENT'S FIRST NAME IS NOT VALID.							1/1/2014	12/31/2299
0821	Nursing home dates of service not payable when billed in current month.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0822	Crossover with missing/invalid data.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M56	Missing/incomplete/invalid payer identifier.	1/1/2014	12/31/2299
0824	OTHER INSURANCE CARRIER CODE IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
0827	INVALID PROCESSOR CONTROL NUMBER. USE CTPCNPVT							1/1/2014	12/31/2299
0835	PROVIDER SPECIALTY CHANGED FOR PORTION OF CLAIM. SUBMIT SEPARATE CLAIM FOR E		3 CO	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/5/2015	12/31/2299
0837	MISSING/INVALID GROUP ID (301-C1)							1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0839	NDC NOT VALID FOR PROCEDURE CODE BILLED		2 CO	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.	1/1/2014	12/31/2299
0840	HCPC REQUIRED WHEN DRUG REVENUE CODE IS BILLED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M20	Missing/incomplete/invalid HCPCS.	1/1/2014	12/31/2299
0841	UNITS OF MEASURE REQUIRED FOR NDC		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N816	Missing/Incomplete/Invalid NDC Unit of Measure	1/2/2020	12/31/2299
0842	NDC UNITS MISSING OR INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N815	Missing/Incomplete/Invalid NDC Unit Count	1/2/2020	12/31/2299
0843	TOO MANY VALUE CODES WITH MEDICARE COINSURANCE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
0844	PROCEDURE CODE NOT PAYABLE FOR PROVIDER		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	9/1/2020	12/31/2299
0845	PROVIDER NOT ALLOWED TO BILL CLAIM TYPE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N34	Incorrect claim form/format for this service.	1/1/2014	12/31/2299
0850	Medicare crossover claims containing deductible cannot span calendar years.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0852	Accommodation days is zero.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
0853	Admission date is required for services performed in an inpatient hospital.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA40	Missing/incomplete/invalid admission date.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0854	The from date of service must equal the first of the month.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0855	NH LEAVE OF ABSENCE REQUIRES OCCURRENCE CODE/DATE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M45	Missing/incomplete/invalid occurrence code(s).	1/1/2014	12/31/2299
0856	Required operating provider number is missing.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N262	Missing/incomplete/invalid operating provider primary identifier.	1/1/2014	12/31/2299
0857	Overlapping detail dates of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1/1/2014	12/31/2299
0858	Immunization administration procedure not covered without immunization code.		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0859	RN services not covered without nursing care or nursing assessment service.		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0860	LPN services not covered without nursing care services on same date of service.		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0861	NDC IS MISSING INVALID OR NON-REBATEABLE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	1/1/2014	12/31/2299
0862	Administratively necessary days for this RCC cannot exceed 7.		3 CO	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.	1/1/2014	12/31/2299
0863	Detail dates of service not within header from and through dates of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1/1/2014	12/31/2299
0864	Covered and non covered days disagree with total detail units.							1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0865	Ambulance cannot bill mileage separately.		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0866	Claim cannot exceed 31 days.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA32	Missing/incomplete/invalid number of covered days during the billing period.	1/1/2014	12/31/2299
0867	Long Term Care detail dates of service are inconsistent with units billed.		3 CO	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.	1/1/2014	12/31/2299
0868	LPN or RN services exceeded.		3 CO	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.	1/1/2014	12/31/2299
0869	FQHC procedure not covered without other services.		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
0870	CLAIM/DETAIL PAID FULL CO-INSURANCE OR COPAY BILLED. COPAY ONLY IF OUTPT XOVR		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0871	CLAIM/DTL PAID FULL CO-INSURANCE&DEDUCTIBLE OR COPAY BILLED. COPAY IF OUTPT XO		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0872	CLAIM/DETAIL PAID FULL DEDUCTIBLE BILLED.		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0873	MANUAL PRICE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.							1/1/2014	12/31/2299
0874	Service included in hospital per diem rate.							1/1/2014	12/31/2299
0875	HCPC not allowed with revenue center code.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0876	HEADER QUANTITY DISAGREES WITH DAYS ELAPSED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
0877	DETAIL QUANTITY DISAGREES WITH DAYS ELAPSED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
0878	ALLOWED AMOUNT IS ZERO MANUAL PRICED OUTPATIENT APC PROVIDER FEE SCHEDULE. IF		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2014	12/31/2299
0879	NO CO-INSURANCE OR DEDUCTIBLE DUE FOR OUTPATIENT LAB SERVICES		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
0880	MEDICARE PART B COINS/DEDUCT RECOUPMENT.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
0885	CLAIM/DETAIL PAID PARTIAL COINSURANCE OR COPAY BILLED. COPAY ONLY IF OUTPT XOVR		3 CO	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments 9/1/2012			5/1/2024	12/31/2299
0888	PAYMENT AMOUNT REDUCED BY CLIENT DEDUCTIBLE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
0889	PAYMENT AMOUNT REDUCED BY CLIENT COINSURANCE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
0890	CHARTER OAK PAYMENT REDUCED BY CO-INSURANCE AND OR DEDUCTIBLE.							1/1/2014	12/31/2299
0891	ANNUAL CHARTER OAK BENEFIT LIMIT MET							1/1/2014	12/31/2299
0893	LIFETIME CHARTER OAK BENEFIT LIMIT MET							1/1/2014	12/31/2299
0895	MH WAIVER PERFORMING PROVIDER MISSING OR NOT VALID PT/PS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N290	Missing/incomplete/invalid rendering provider primary identifier.	1/1/2014	12/31/2299
0896	PROCEDURE NOT BILLABLE WITH RCC		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	4/1/2015	12/31/2299
0899	DENTAL FQHC PROCEDURE NOT PAYABLE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0907	CLAIM DENIED. NO CHARTER OAK COST SHARE DATA FOR CLAIM DATES OF SERVICE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
0912	PROVIDER TYPE AND SPECIALTY CANNOT BE FOUND							1/1/2014	12/31/2299
0920	3M GROUPER ERROR		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	12/24/2014	12/31/2299
0928	APC GROUPER ERROR		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299
0999	RECYCLE CLAIM TABLE OVERFLOW. CONTACT THE PROVIDER ASSISTANCE CENTER.							1/1/2014	12/31/2299
1000	BILLING PROVIDER IDENTIFIER IS NOT ON FILE.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1001	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.		3 CO	299	The billing provider is not eligible to receive payment for the service billed.	N767	The Medicaid state requires provider to be enrolled in the member?s Medicaid state program prior to any claim benefits being processed.	1/2/2020	12/31/2299
1003	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.							1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
1004	PROVIDER NOT ALLOWED TO BILL FROM THIS SERVICE LOCATION		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N55	Procedures for billing with group/referring/performing providers were not followed.	1/1/2014	12/31/2299
1007	The performing provider is not on file.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1008	PERFORMING PROVIDER MUST HAVE AN INDIVIDUAL NUMBER		3 CO	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/4/2014	12/31/2299
1010	Performing provider is not a member of the billing provider group.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1011	PERFORMING PROVIDER NUMBER NOT A VALID FORMAT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N32	Claim must be submitted by the provider who rendered the service.	1/1/2014	12/31/2299
1013	PERFORMING PROVIDER NOT ACTIVE ON CLAIM DATE OF SERVICE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N55	Procedures for billing with group/referring/performing providers were not followed.	1/1/2014	12/31/2299
1014	PERFORMING PROVIDER MUST BE ACTIVE		3 CO	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/4/2014	12/31/2299
1018	No rate on file. Contact the Provider Assistance Center.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
1024	PROVIDER IS NOT AUTHORIZED TO BILL FOR THIS CLIENT.		3 CO	171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: 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.	1/1/2014	12/31/2299
1025	OUT OF STATE PROVIDER DOES NOT HAVE A VALID LICENSE ON FILE FOR CLAIM DATES OF		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			12/1/2016	12/31/2299
1029	ORDERING PROVIDER MISSING WHEN REQUIRED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N285	Missing/incomplete/invalid referring provider name.	1/1/2014	12/31/2299
1031	SERVICE LOCATION PROVIDER NOT ENROLLED ON DATE OF SERVICE							1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
1033	ATTENDING PHYSICIAN NOT ENROLLED ON DATE OF SERVICE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2016	12/31/2299
1034	INFORMATIONAL ONLY - RENDERING PROVIDER NOT ENROLLED ON DATE OF SERVICE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1035	REFERRING PROVIDER NOT ENROLLED ON DATE OF SERVICE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1036	ORDERING PROVIDER NOT ENROLLED ON DATE OF SERVICE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1038	REFERRING PROVIDER MISSING WHEN REQUIRED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N265	Missing/incomplete/invalid ordering provider primary identifier.	1/1/2014	12/31/2299
1039	REFERRING PROVIDER MISSING WHEN REQUIRED.							1/1/2014	12/31/2299
1040	ORDERING/REFERRING/ATTENDING PROVIDER IS NOT ENROLLED ON DATE OF SERVICE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N253	Missing/incomplete/invalid attending provider primary identifier.	1/1/2014	12/31/2299
1042	RESIDENT NOT ALLOWED AS ATTENDING PROVIDER		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N253	Missing/incomplete/invalid attending provider primary identifier.	1/1/2014	12/31/2299
1043	BH BILLING PROVIDER ATTESTATION NEEDS TO BE SIGNED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA70	Missing/incomplete/invalid provider representative signature.	8/1/2023	12/31/2299
1046	BH RENDERING ATTESTATION NEEDS TO BE SIGNED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA70	Missing/incomplete/invalid provider representative signature.	8/1/2023	12/31/2299
1047	BH BILLING PROVIDER ATTESTATION NOT VALID ON CLAIM DATE OF SERVICE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1/1/2023	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
1051	Performing provider not on file.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1059	BH RENDERING ATTESTATION NOT VALID ON CLAIM DATE OF SERVICE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1/1/2023	12/31/2299
1800	CLAIM MUST BE SUBMITTED ELECTRONICALLY.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M117	Not covered unless submitted via electronic claim.	1/1/2014	12/31/2299
1802	Type of bill is invalid for the provider.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
1803	SOCIAL SECURITY NUMBER/EMPLOYER'S IDENTIFICATION NUMBER IS MISSING OR INVALID.		2 CO	206	NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.	N291	Missing/incomplete/invalid rendering provider secondary identifier.	1/1/2014	12/31/2299
1804	CROSSOVER CLAIMS ARE NOT PAYABLE FOR BEHAVIORAL HEALTH-ONLY PROVIDERS.							1/1/2014	12/31/2299
1900	BILLING PROVIDER'S TAXONOMY IS INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N255	Missing/incomplete/invalid billing provider taxonomy.	1/1/2014	12/31/2299
1906	HEADER BILLING PROVIDER'S TAXONOMY IS NOT VALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N255	Missing/incomplete/invalid billing provider taxonomy.	1/1/2014	12/31/2299
1912	BILLING PROVIDER'S TAXONOMY IS MISSING		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N255	Missing/incomplete/invalid billing provider taxonomy.	1/1/2014	12/31/2299
1927	THE BILLING PROVIDER'S NPI IS MISSING OR INVALID.		2 CO	208	NPI denial - not matched. This change to be effective 4/1/2008: National Provider Identifier - Not matched.	N433	Resubmit this claim using only your National Provider Identifier (NPI)	1/1/2014	12/31/2299
1928	The performing provider's NPI is missing or invalid on the claim.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N433	Resubmit this claim using only your National Provider Identifier (NPI)	1/1/2014	12/31/2299
1931	The rendering provider's NPI is missing or invalid.							1/1/2014	12/31/2299
1934	The performing provider's NPI is missing or invalid on the claim detail.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N433	Resubmit this claim using only your National Provider Identifier (NPI)	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
1938	REFERRING PROVIDER NOT ENROLLED ON DATE OF SERVICE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1944	REFERRING PROVIDER NOT ENROLLED ON DATE OF SERVICE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
1945	CLAIM/DETAIL DENIED. BILLING/PERFORMING PROVIDER COULD NOT BE DETERMINED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N433	Resubmit this claim using only your National Provider Identifier (NPI)	1/1/2014	12/31/2299
2001	CLIENT ID IS INVALID OR NOT ON FILE. REFERENCE ID CARD FOR CORRECT NUMBER.		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
2002	CLIENT INELIGIBLE FOR DATES OF SERVICE.		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2014	12/31/2299
2003	CLIENT INELIGIBLE FOR DATES OF SERVICE.		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2014	12/31/2299
2012	CLIENT IS NOT ELIGIBLE FOR ALL DATES OF SERVICE		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2015	12/31/2299
2017	SERVICE IS INCLUDED IN MCO COVERAGE.		4 CO	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.			1/1/2014	12/31/2299
2057	Client ineligible for portion of claim. Resubmit for covered days only.		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2014	12/31/2299
2077	Client ineligible for portion of claim detail. Resubmit for covered days only.		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2014	12/31/2299
2078	CLIENT'S BENEFIT PLAN DOES NOT COVER CROSSOVER CLAIMS.		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			1/1/2014	12/31/2299
2079	INCORRECT PROCEDURE CODE USED.							1/1/2014	12/31/2299
2100	CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM.		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
2101	CLIENT IS NOT ELIGIBLE ON ELIGIBILITY MANAGEMENT SYSTEM.		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
2102	CLIENT ELIGIBILITY SYSTEM IS NOT CURRENTLY AVAILABLE.		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
2103	UNABLE TO DETERMINE CLIENT ELIGIBILITY DUE TO INVALID CLIENT ID INVALID DATE O		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
2104	CONNPACE ID IS IN AN INVALID FORMAT		2 CO	140	Patient/Insured health identification number and name do not match.			1/1/2014	12/31/2299
2105	OVERLAPPING PATIENT LIABILITY SEGMENTS		3 PR	177	Payment denied because the patient has not met the required eligibility requirements			10/1/2016	12/31/2299
2500	Bill Medicare first.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299
2501	Bill Medicare first.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299
2502	Bill Medicare first.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299
2503	Bill Medicare first.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299
2504	BILL PRIVATE CARRIER FIRST OR INVALID ADJUSTMENT REASON CODE BILLED.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	9/10/2016	12/31/2299
2505	Bill private carrier first. Claim attachment is invalid.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299
2506	HEADER AND DETAIL OTHER PAYER PAID AMOUNTS DO NOT BALANCE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
2507	Client has more than one private insurance carrier.							1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
2513	OTHER PAYER ADJUDICATION DATE IS INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
2515	CLAIM OTHER PAYER CARRIER CODE IS NOT ON FILE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
2516	Claim adjustment reason code is invalid.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
2517	CLAIM OTHER PAYER ADJUDICATION INFORMATION IS INCOMPLETE		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	1/1/2014	12/31/2299
2518	Other Insurance Explanation of Benefits is missing							1/1/2014	12/31/2299
2519	OTHER PAYER ADJUSTMENT AMOUNT IS INVALID		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	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.	1/1/2014	12/31/2299
2520	DUPLICATE CARRIER SUBMITTED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	1/1/2014	12/31/2299
2522	BILL MEDICARE FIRST OR PROVIDE APPROPRIATE ADJUSTMENT REASON CODE AND DAT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	1/1/2014	12/31/2299
2530	CLIENT DOES NOT HAVE MEDICARE COVERAGE ON CLAIM DATES OF SERVICE		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2021	12/31/2299
2531	CLAIM PAYMENT OR ADJUDICATION DATE MISSING		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299
2532	NO HEADER PAYMENT OR CAS SEGMENTS SUBMITTED		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
2533	NO DETAIL PAYMENT OR DETAIL CAS SEGMENTS AND NO HEADER CAS SEGMENTS SUBMITTED		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299
2534	DETAIL PAYMENT OR DETAIL CAS SEGMENTS MISSING WHEN HEADER CAS SEGMENTS SUBMITTE		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299
2535	NO VALID OTHER PAYER ID SUBMITTED AT THE DETAIL		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299
2536	INELIGIBLE FOR PAYMENT AS NO MEDICARE PAYMENT SUBMITTED ON DETAIL		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299
2537	DETAIL MEDICARE PAID AMOUNT MISSING		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	9/1/2021	12/31/2299
2550	Other payer claim adjustment reason code restriction.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
2602	DATES OF SERVICE ARE OUTSIDE LOCK-IN EFFECTIVE DATES.							1/1/2014	12/31/2299
2603	PROVIDER NOT AUTHORIZED TO BILL FOR CLIENT.		3 CO	171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: 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.	1/1/2014	12/31/2299
2604	THIS CLIENT'S BENEFIT IS RETRICTED TO A SPECIFIC DIAGNOSIS.							1/1/2014	12/31/2299
2800	DATE OF SERVICE SUBMITTED IS AFTER THE CLIENT'S DATE OF DEATH.		2 CO	13	The date of death precedes the date of service.			1/1/2014	12/31/2299
2805	Date of service submitted is prior to client's date of birth.		2 OA	14	The date of birth follows the date of service.			1/1/2014	12/31/2299
2807	Client's date of birth is not on file. Contact DSS for eligibility corrrection.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N329	Missing/incomplete/invalid patient birth date.	1/1/2014	12/31/2299
2808	SAGA CLAIM WITH DATES OF SERVICE PRIOR TO 4/1/2010 NO LONGER COVERED							1/1/2014	12/31/2299
2827	MEDICARE PART D CO-PAY SUBMITTED IS GREATER THAN THE ALLOWED MAXIMUM		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re			1/1/2018	12/31/2299
3000	PRIOR AUTHORIZATION SERVICES ARE CUTBACK OR EXHAUSTED.		3 CO	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	1/1/2014	12/31/2299
3003	Prior authorization is required for payment of this service.		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			1/1/2016	12/31/2299
3004	Inpatient claim requires prior authorization		3 CO	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
3006	Prior authorization dollars are exhausted.		3 CO	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	1/1/2014	12/31/2299
3009	VO PA NOT ON FILE		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			5/1/2018	12/31/2299
3010	Out of state non-emergency services require prior authorization.		3 CO	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	1/1/2014	12/31/2299
3011	PA REQUIRED FOR CDH INPATIENT STAY		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			9/4/2014	12/31/2299
3013	SERVICE REQUIRES A PROFESSIONAL PRIOR AUTHORIZATION		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			7/1/2016	12/31/2299
3015	CARE PLAN REQUIRED		3 CO	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.	1/1/2014	12/31/2299
3016	SERVICE NOT COVERED UNDER CARE PLAN		3 CO	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.	1/1/2014	12/31/2299
3017	PROVIDER NOT ALLOWED TO SUBMIT CLAIMS FOR THIS CARE PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2016	12/31/2299
3019	Prior authorization cutback performed.							1/1/2014	12/31/2299
3021	DRG requires prior authorization.							1/1/2014	12/31/2299
3102	PA REQUIRED FOR PRESCRIPTIONS GREATER THAN $500.00.							1/1/2014	12/31/2299
3103	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION.							1/1/2014	12/31/2299
3306	CLAIM DETAIL EXCEEDS ALLOWABLE LIMIT. CONTACT THE PROVIDER ASSISTANCE CENTER.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
3310	BILLED AMOUNT IS GREATER THAN ALLOWED AMOUNT - PRIOR AUTHORIZATION REQUIRED.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M79	Missing/incomplete/invalid charge.	1/1/2014	12/31/2299
3311	Claim dates of service overlap rate change. Rebill on two separate claims.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
3312	Other insurance amount is greater than or equal to the allowed amount.							1/1/2014	12/31/2299
3313	Freestanding alcohol clinic visits limited to 10 consecutive days.		3 CO	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.	1/1/2014	12/31/2299
3315	ATP TABLE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M53	Missing/incomplete/invalid days or units of service.	1/1/2014	12/31/2299
3325	LCA DETAIL DOS SPAN 2 PROVIDER TIERS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N62	Dates of service span multiple rate periods. Resubmit separate claims.	1/1/2014	12/31/2299
3326	LCA DETAIL DOS SPAN 2 PROVIDER TIERS		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N62	Dates of service span multiple rate periods. Resubmit separate claims.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
3327	CONFIRMED VISIT NOT FOUND		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N821	Electronic Visit Verification System visit not found.	1/2/2020	12/31/2299
3328	CONFIRMED VISIT UNITS ARE EXHAUSTED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N820	Electronic Visit Verification System units do not meet requirements of visit.	1/2/2020	12/31/2299
3329	DETAIL DATE OF SERVICE RANGE THAT EXCEEDS 31 DAYS CANNOT BE VERIFIED		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	7/1/2016	12/31/2299
3331	NON-WAIVER CONFIRMED VISIT NOT FOUND		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			1/1/2023	12/31/2299
3332	NON-WAIVER CONFIRMED VISIT UNITS ARE EXCEEDED		3 CO	198	Precertification/notification/authorization/pre-treatment exceeded.			1/1/2023	12/31/2299
3400	SUSPENDED DME MANUALLY PRICED CLAIM CURRENTLY UNDER REVIEW.		1 CO	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).			7/1/2024	12/31/2299
3600	Procedure billed by provider is not covered under the client's benefit plan.							1/1/2014	12/31/2299
4001	The diagnosis is not covered by this provider under the client's benefit plan.							1/1/2014	12/31/2299
4012	Claim denied after Medical Policy review.							1/1/2014	12/31/2299
4013	Procedure code is not active for this date of service		3 CO	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.	1/1/2014	12/31/2299
4014	NO PRICING SEGMENT IS ON FILE.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4021	The procedure billed is not a covered service under the client's benefit plan.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4022	Claim denied after Medical Policy review.							1/1/2014	12/31/2299
4023	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S GENDER.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2016	12/31/2299
4027	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			10/1/2015	12/31/2299
4030	THE DIAGNOSIS IS NOT CONSISTENT WITH THE CLIENT'S AGE.		3 CO	9	The diagnosis is inconsistent with the patient's age. Usage: 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.	9/5/2015	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4031	THE DIAGNOSIS IS NOT CONSISTENT WITH THE CLIENT'S GENDER.		3 CO	10	The diagnosis is inconsistent with the patient's gender. Usage: 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.	9/4/2014	12/31/2299
4032	Procedure code is not on file.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4034	The service billed does not meet Connecticut Medicaid age criteria guidelines.		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
4035	The procedure is not consistent with the client's gender.		3 CO	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/5/2015	12/31/2299
4036	Place of service is invalid for this procedure.		3 CO	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M77	Missing/incomplete/invalid/inappropriate place of serivce.	1/1/2014	12/31/2299
4039	The primary diagnosis code is not covered.							1/1/2014	12/31/2299
4040	THE PRIMARY DIAGNOSIS CODE IS INCOMPLETE OR INVALID		2 CO	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	MA63	Missing/incomplete/invalid principal diagnosis.	1/1/2014	12/31/2299
4041	SECONDARY DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M64	Missing/incomplete/invalid other diagnosis.	1/1/2014	12/31/2299
4042	THIRD DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
4043	FOURTH DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
4044	No reimbursement rule for associated client age		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
4045	Benefit plan restriction on reimbursement agreement.		3 CO	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.	1/1/2014	12/31/2299
4046	PROCEDURE CODE BILLED PRIOR TO THE EFFECTIVE DATE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4047	FIFTH DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
4048	SIXTH DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	10/1/2015	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4049	SEVENTH DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	10/1/2015	12/31/2299
4050	EIGHTH DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	10/1/2015	12/31/2299
4051	NINTH DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	10/1/2015	12/31/2299
4052	THE ADMIT DIAGNOSIS CODE IS INCOMPLETE OR INVALID.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA65	Missing/incomplete/invalid admitting diagnosis.	1/1/2014	12/31/2299
4053	PRINCIPAL PROCEDURE CODE IS INCOMPLETE OR INVALID.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4054	SECOND PROCEDURE CODE IS INCOMPLETE OR INVALID.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4055	THIRD PROCEDURE CODE IS INCOMPLETE OR INVALID.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4056	THE FOURTH SURGICAL PROCEDURE CODE IS INCOMPLETE OR INVALID.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4057	THE FIFTH SURGICAL PROCEDURE CODE IS INCOMPLETE OR INVALID		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4058	THE SIXTH SURGICAL PROCEDURE CODE IS INCOMPLETE OR INVALID.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	10/1/2015	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4059	Revenue center code is not on file.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M50	Missing/incomplete/invalid revenue code(s).	1/1/2014	12/31/2299
4061	NO REIMB RULE FOR ASSOCIATED CLAIM TYPE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N34	Incorrect claim form/format for this service.	1/1/2014	12/31/2299
4067	NON-COVERED ICD PROCEDURE CODE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	10/1/2015	12/31/2299
4068	Service is not active on file on date of service.		3 CO	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.			1/1/2014	12/31/2299
4070	MODIFIER RESTRICTION FOR PROCEDURE CODE		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: 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.	9/1/2020	12/31/2299
4077	Revenue center code not active on file on date of service.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
4093	Diagnosis is restricted under the client's benefit plan.		3 CO	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M77	Missing/incomplete/invalid/inappropriate place of serivce.	1/1/2014	12/31/2299
4099	Diagnosis related group not on file.							1/1/2014	12/31/2299
4105	NO RCC FLAT RATE ON FILE		4 CO	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.	7/1/2016	12/31/2299
4115	NO ANESTHESIA CONVERSION FACTOR ON FILE. CONTACT THE PROVIDER ASSISTANCE CENTER							1/1/2014	12/31/2299
4120	PROCEDURE CODE REQUIRES VALID QUADRANT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N37	Missing/incomplete/invalid tooth number/letter.	1/1/2014	12/31/2299
4127	BENEFIT PLAN HIERARCHY IS NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
4128	SURGICAL CODE 7 - 24 IS INCOMPLETE OR INVALID		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	10/1/2015	12/31/2299
4130	PAYER HIERARCHY NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4131	NO BENEFIT PLAN ASSOCIATED TO PAYER. CONTACT THE PROVIDER ASSISTANCE CENTER.		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
4132	DRG grouper is unable to assign DRG for pricing.							1/1/2014	12/31/2299
4140	The service submitted is not covered under the client's benefit plan.		3 CO	299	The billing provider is not eligible to receive payment for the service billed.	N95	This provider type/provider specialty may not bill this service.	1/2/2020	12/31/2299
4142	Provider cannot bill this RCC according to the client's benefit plan.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4149	Billing provider not authorized to bill for submitted procedure code.		3 CO	299	The billing provider is not eligible to receive payment for the service billed.	N95	This provider type/provider specialty may not bill this service.	1/2/2020	12/31/2299
4151	Billing provider not authorized to bill for submitted service for client.		3 CO	299	The billing provider is not eligible to receive payment for the service billed.	N95	This provider type/provider specialty may not bill this service.	1/2/2020	12/31/2299
4155	No reimbursement rule for the associated facility type		3 CO	171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: 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.	1/1/2014	12/31/2299
4156	NO RELATIVE VALUE ON FILE FOR ANESTHESIA PROCEDURE. CONTACT THE PROVIDER ASSIST							1/1/2014	12/31/2299
4161	Procedure code is restricted under provider's contract.							1/1/2014	12/31/2299
4162	Revenue center code is restricted under provider's contract.		3 CO	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.	1/1/2014	12/31/2299
4182	The ICD-9 procedure is not consistent with the client's gender.		3 CO	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/5/2015	12/31/2299
4185	SERVICE NOT COVERED UNDER APC ADDENDUM B		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	7/1/2016	12/31/2299
4200	Zero allowed amount. Contact the Provider Assistance Center.							1/1/2014	12/31/2299
4206	Quantity is restricted for procedure under provider contract.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4207	CLIA certification not on file for billed dates of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	MA120	Missing/incomplete/invalid CLIA certification number.	1/1/2014	12/31/2299
4208	CLIA laboratory procedure requires a modifier.		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: 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.	1/1/2014	12/31/2299
4209	Procedure/modifier combination is not active on file on date of service.							1/1/2014	12/31/2299
4211	Tooth number is non-covered for the procedure code billed.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N39	Procedure code is not compatible with tooth number/letter.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4212	Services not covered by CLIA certificate.		3 CO	B23	Payment denied because this provider has failed an aspect of a proficiency testing program.			1/1/2014	12/31/2299
4219	Type of bill restriction under reimbursement agreement.							1/1/2014	12/31/2299
4223	This procedure was denied after DSS review.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N35	Program integrity/utilization review decision.	1/1/2014	12/31/2299
4224	Quantity limit exceeded.		3 CO	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.	1/1/2014	12/31/2299
4227	The RCC billed is not a covered service under the client's benefit plan.		3 CO	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.	1/1/2014	12/31/2299
4229	This diagnosis was denied after DSS review.							1/1/2014	12/31/2299
4240	Only one date of service allowed per detail.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4244	Diagnosis is not covered under the client's benefit plan.							1/1/2014	12/31/2299
4245	Fourth modifier invalid for the date of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N823	Incomplete/Invalid procedure modifier(s).	1/2/2020	12/31/2299
4248	Procedure code requires a modifier.							1/1/2014	12/31/2299
4249	MODIFIER REQUIRED OR NOT ALLOWED FOR PROVIDER TYPE AND SPECIALTY		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4250	No reimbursement rule for the associated provider type/provider specialty		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: 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.	1/1/2014	12/31/2299
4252	DX CODE 10-24 INCOMPLETE OR INVALID		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	10/1/2015	12/31/2299
4259	The revenue center code is not consistent with the client's age.		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
4260	PATIENT REASON FOR VISIT NOT ON FILE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M76	Missing/incomplete/invalid diagnosis or condition.	1/1/2014	12/31/2299
4270	NO VALID REIMB RULE FOR PROCEDURE CODE BILLED		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: 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.	1/1/2021	12/31/2299
4271	Modifier conflict for procedure code under provider contract.							1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4272	Procedure code and modifier combination is not valid for billing provider.		2 CO	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N519	Invalid combination of HCPCS modifiers.	1/1/2014	12/31/2299
4280	HIC GROUP RESTRICTION FOR PROCEDURE UNDER PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2021	12/31/2299
4281	HIC GROUP RESTRICTION FOR PROCEDURE UNDER CLIENT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2021	12/31/2299
4282	GCN GROUP RESTRICTION FOR PROCEDURE UNDER PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2021	12/31/2299
4283	GCN GROUP RESTRICTION FOR PROCEDURE UNDER CLIENT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2021	12/31/2299
4284	NDC GROUP RESTRICTION FOR PROCEDURE UNDER PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2021	12/31/2299
4285	NDC GROUP RESTRICTION FOR PROCEDURE UNDER CLIENT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2021	12/31/2299
4290	PROVIDER CERTIFICATION RESTRICTION FOR BILLED PROC UNDER PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2022	12/31/2299
4291	PROVIDER CERTIFICATION RESTRICTION FOR COVERED PROC UNDER CLIENT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2022	12/31/2299
4292	NO REIMBURSEMENT RULE FOR ASSOCIATED PROVIDER CERTIFICATION		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2022	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4293	PROVIDER CERTIFICATION RESTRICTION FOR BILLED REV CODE UNDER PROVIDER CONTRACT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2022	12/31/2299
4294	PROVIDER CERTIFICATION RESTRICTION FOR COVERED REV CODE UNDER CLIENT PLAN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2022	12/31/2299
4311	PRIMARY HEADER DIAGNOSIS RESTRICTION FOR PROCEDURE CODE UNDER PROVIDER CONTRACT		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
4312	PRIMARY DTL DIAG RESTRICTION FOR BILLED PROC		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
4321	PRIMARY HDR DIAG RESTRICTION FOR BILLED REV CDE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N569	Not covered when performed for the reported diagnosis.	1/1/2014	12/31/2299
4350	REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE SERVICE BILLED.		3 CO	183	The referring provider is not eligible to refer the service billed. Usage: 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.	9/4/2014	12/31/2299
4371	THIS TYPE OF CLAIM IS NOT COVERED UNDER THE CLIENT'S BENEFIT PLAN.							1/1/2014	12/31/2299
4372	SECONDARY HEADER DIAGNOSIS RESTRICTION FOR PROCEDURE CODE UNDER PROVIDER CONTRA		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
4374	Revenue center code is not billable.							1/1/2014	12/31/2299
4714	Service billed does not meet age criteria according to the provider's contract.		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
4715	This revenue center code is not consistent with the client's age.		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
4731	ANY DTL DIAG RESTRICTION FOR COVERED PROC		3 CO	11	The diagnosis is inconsistent with the procedure. Usage: 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.	9/4/2014	12/31/2299
4733	Diagnosis is restricted for revenue center code under client's benefit plan.							1/1/2014	12/31/2299
4736	The revenue center code is not consistent with the billed diagnosis.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N569	Not covered when performed for the reported diagnosis.	1/1/2014	12/31/2299
4742	THE PROCEDURE IS NOT CONSISTENT WITH THE HEADER DIAGNOSIS BASED ON THE CLIENTS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N569	Not covered when performed for the reported diagnosis.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4743	The procedure is not consistent with the detail diagnosis.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N569	Not covered when performed for the reported diagnosis.	1/1/2014	12/31/2299
4744	SECONDARY HEADER DIAGNOSIS RESTRICTION FOR THE PROCEDURE CODE UNDER BENEFIT PLA		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N607	Service provided for non-compensable condition(s).	1/1/2014	12/31/2299
4745	HEADER DIAGNOSIS RESTRICTION FOR PROCEDURE CODE		3 CO	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N607	Service provided for non-compensable condition(s).	1/1/2017	12/31/2299
4766	The ICD-9 procedure is not consistent with the client's gender.		3 CO	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N129	This amount represents the dollar amount not eligible due to the patient's age.	1/1/2014	12/31/2299
4780	STATUS INDICATOR GROUP RESTRICTION FOR COVERED PROCEDURE		2 CO	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	9/10/2016	12/31/2299
4781	APC GROUP RESTRICTION FOR COVERED PROCEDURE		2 CO	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	9/10/2016	12/31/2299
4782	PHS PROVIDER INDICATOR RESTRICTION FOR COVERED PROCEDURE		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299
4783	STATUS INDICATOR GROUP RESTRICTION FOR COVERED REVENUE CODE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
4784	STATUS INDICATOR GROUP RESTRICTION FOR COVERED REVENUE CODE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
4785	PHS PROVIDER INDICATOR RESTRICTION FOR COVERED REVENUE CODE		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299
4786	NO REIMBURSEMENT RULE FOR ASSOCIATED STATUS INDICATOR		3 CO	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present	N229	Incomplete/invalid contract indicator.	7/1/2016	12/31/2299
4787	NO REIMBURSEMENT RULE FOR ASSOCIATED APC		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	7/1/2016	12/31/2299
4788	NO REIMBURSEMENT RULE FOR ASSOCIATED PROVIDER SET		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4789	NO REIMBURSEMENT RULE FOR 340B INDICATOR		3 CO	170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299
4801	PROCEDURE NOT COVERED. CHECK: PRIOR AUTHORIZATION FTC REFERRING PROVIDER QU		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
4804	Revenue center code is not billable under provider contract.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
4821	Facility type is restricted for procedure under provider contract.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4829	PROVIDER NOT AUTHORIZED TO BILL RCC		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M50	Missing/incomplete/invalid revenue code(s).	7/1/2016	12/31/2299
4830	DRG RESTRICTION FOR REIMBURSEMENT AGREEMENT		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N647	Adjusted based on diagnosis-related group (DRG).	1/1/2015	12/31/2299
4831	Service is not payable on date of service.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2014	12/31/2299
4832	NO REIMBURSEMENT RULE FOR ASSOCIATED BILLED AMOUNT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	8/1/2017	12/31/2299
4871	Invalid claim type for procedure code submitted.							1/1/2014	12/31/2299
4874	Invalid claim type for revenue center code submitted.							1/1/2014	12/31/2299
4951	CONDITION CODE RESTRICTION FOR BILLED ICD PROCEDURE CODE UNDER PROVIDER CONTRAC		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	10/1/2015	12/31/2299
4954	SERVICE RESTRICTION FOR PROCEDURE UNDER BENEFIT PLAN		3 CO	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.	1/1/2014	12/31/2299
4955	SERVICE RESTRICTION FOR PROCEDURE UNDER REIMBURSEMENT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2016	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4956	SERVICE RESTRICTION FOR PROCEDURE UNDER PROVIDER CONTRACT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1/1/2016	12/31/2299
4957	SERVICE RESTRICTION FOR REVENUE UNDER BENEFIT PLAN.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4958	SERVICE RESTRICTION FOR REVENUE UNDER REIMBURSEMENT.		3 CO	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.	1/1/2014	12/31/2299
4959	SERVICE RESTRICTION FOR REVENUE UNDER PROVIDER CONTRACT		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
4963	Gender is restricted for procedure code under provider contract.		3 CO	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/5/2015	12/31/2299
4967	The revenue center code is not consistent with the client's gender.		3 CO	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			9/5/2015	12/31/2299
4970	THE REVENUE CENTER CODE BILLED IS RESTRICTED UNDER THE CLIENT'S BENEFIT PLAN.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4975	The revenue center code billed is restricted under the provider's contract.							1/1/2014	12/31/2299
4980	The procedure billed is restricted under the client's benefit plan.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4984	PROCEDURE RESTRICTION FOR RCC UNDER BENEFIT PLAN.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4985	PROCEDURE RESTRICTION FOR RCC UNDER PROVIDER CONTRACT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
4986	PROCEDURE RESTRICTION FOR RCC UNDER REIMBURSEMENT AGREEMENT.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
4990	BENEFIT PLAN RESTRICTION FOR PROCEDURE CODE		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2015	12/31/2299
4991	CONDITION CODE RESTRICTION FOR BILLED PROCEDURE UNDER PROVIDER CONTRACT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M44	Missing/incomplete/invalid condition code.	10/1/2015	12/31/2299
5000	POSSIBLE DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5001	EXACT DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5005	DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5007	EXACT DUPLICATE - HEADER OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCES		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5008	Duplicate of a paid claim or a claim that is currently in process.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5010	EXACT DUPLICATE DENTAL CLAIM OF A PAID OR PENDING CLAIM.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5011	Duplicate tooth surface or billing provider of a paid or pending claim.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5016	HOSPICE DUPLICATE		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5017	DUPLICATE SERVICE PD TO NH OR HOSPICE		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5018	SURFACE B & F NOT PAYABLE TOGETHER - EQUAL SURFACES		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N75	Missing/incomplete/invalid tooth surface information.	1/1/2014	12/31/2299
5020	Duplicate coinsurance billed.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5021	Duplicate coinsurance billed.		3 CO	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.	1/1/2014	12/31/2299
5022	Duplicate coinsurance billed.		3 CO	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.	1/1/2014	12/31/2299
5024	NDC - HCPCS COMBINATION IS AN EXACT DUPLICATE OF A PAID OR IN PROCESS CLAIM DET		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	7/1/2016	12/31/2299
5025	APC DUPLICATE CLAIM. APC SERVICES MUST BE ON SAME CLAIM FOR DATE OF SERVICE		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	7/1/2016	12/31/2299
5026	DUPLICATE - LARC INSERTION ALREADY PAID FOR DATE OF SERVICE		3 CO	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.	1/1/2021	12/31/2299
5040	NO PAID ROUTINE HOME CARE SERVICE ON SAME CLAIM		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M67	Missing/incomplete/invalid other procedure code(s).	1/1/2016	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5050	ENCOUNTER CLAIM EXACT DUPLICATE-HEADER							1/1/2014	12/31/2299
5052	ENCOUNTER DUPLICATE MCO ICN							1/1/2014	12/31/2299
5075	ONLY ONE INTERIM CLAIM ALLOWED PER STAY		3 CO	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.	9/1/2017	12/31/2299
5076	PAID INTERIM AND FINAL CLAIM FOR SAME ADMISSION NOT ALLOWED		3 CO	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.	9/1/2017	12/31/2299
5077	INPATIENT STAY DENIED DUE TO A PAID OUTPATIENT CLAIM WITHIN 3 DAYS PRIOR TO INP		3 CO	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.	10/27/2015	12/31/2299
5078	OUTPATIENT CLAIM DENIED DUE TO A PAID INPATIENT CLAIM ON OR WITHIN 3 DAYS AFTER		3 CO	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.	5/1/2016	12/31/2299
5150	This service is limited to once in a client's lifetime.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N117	This service is paid only once in a patient's lifetime.	1/1/2014	12/31/2299
5151	UNITS EXCEED FREQUENCY UNITS ON THE CARE PLAN		3 CO	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	1/1/2014	12/31/2299
5200	Psychotherapy w/evaluation and pharmacological mgmt not covered on same DOS.		3 CO	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.	1/1/2014	12/31/2299
5202	Behavioral health and substance abuse intensive OP not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5203	Behavioral health and psychiatric intensive outpatient not covered on same DOS.		3 CO	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.	1/1/2014	12/31/2299
5204	Behavioral health and day treatment not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5205	Skilled nursing and prenatal services are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5206	Duplicate of a service paid.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5207	Duplicate of a service paid.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5208	Duplicate of a service paid.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5209	DUPLICATE OF A SERVICE PAID.		2 OA	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1/1/2014	12/31/2299
5210	Service previously paid under another procedure code.		3 CO	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.	1/1/2014	12/31/2299
5211	Duplicate dental service.		3 CO	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.	1/1/2014	12/31/2299
5212	Duplicate alveoloplasty service.		3 CO	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.	1/1/2014	12/31/2299
5213	Pharmacological management and E&M codes not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5214	Demo and congregate services not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5215	Congregate and demo services not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5216	Medication code and intensive OP/day treatments not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5217	PERSONAL SUPPORT AND SUPPORTED LIVING/RES HABILITATION NOT COVERED ON SAME DOS.		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5218	ALS and ground mileage not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5219	TORCH panels and components are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5220	RHC RCC MUST BE BILLED WITH RN-SW SVC FOR THE SAME CLIENT/PROVIDER/DATE OF SERV		3 CO	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.	1/1/2016	12/31/2299
5221	General health panel and panel components are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5224	Comprehensive metabolic panel and other panels are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5225	Lipid panel and component are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5226	Electrolyte and components are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5227	Acute hepatitis and components are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5230	Renal panel and other panels are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5237	Hepatic panel and component are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5242	Health & behavior assessments not covered on same DOS as psychiatry/eval mgmt.		3 CO	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.	1/1/2014	12/31/2299
5244	Only one antepartum care code allowed per pregnancy.		3 CO	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.	1/1/2014	12/31/2299
5245	Refitting/reconditioning is not covered same date of service as other services.		3 CO	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.	1/1/2014	12/31/2299
5246	Independent living skill/group & ind not covered same DOS day habilitation.		3 CO	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.	1/1/2014	12/31/2299
5247	Family training/day habilitation not covered on same DOS cognitive service.		3 CO	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.	1/1/2014	12/31/2299
5248	Supported employment not covered same date of service pre-vocational services.		3 CO	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.	1/1/2014	12/31/2299
5249	Day rehab/sub abuse/per hour not covered same DOS sub abuse/per day.		3 CO	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.	1/1/2014	12/31/2299
5250	Transitional living service not covered same date of service as other services.		3 CO	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.	1/1/2014	12/31/2299
5251	Refractive exam not covered same date of service as complete eye exam.		3 CO	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.	1/1/2014	12/31/2299
5253	Stationary gas system and liquid oxygen system not covered within 28 days.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5254	Stationary liquid system and portable system not covered within 28 days.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5255	Habilitative services limited to one per date of service.		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5256	ADP/MR waiver services and CHC/CBS waiver services not covered on same DOS.		3 CO	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.	1/1/2014	12/31/2299
5257	Complete screenings and partial screenings are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5258	Complete screenings and partial screenings not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5259	Complete HH screenings and partial HH screenings are not covered on same DOS.		3 CO	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.	1/1/2014	12/31/2299
5260	Clinic visits and EPSDT screenings are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5261	Surgical procedures and est patient office visit not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5262	Payment for surgical procedure includes follow up hospital care.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5263	PRIMARY SURGERY MUST BE PAID BEFORE MULTIPLE ADDITIONAL SURGERY CAN BE PAID		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
5264	Only one new exam allowed every 3 years per provider per client.		3 CO	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.	1/1/2014	12/31/2299
5267	Global delivery and separate del/antepartum within 180 days are not covered.		3 CO	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.	1/1/2014	12/31/2299
5268	Postpartum service not covered within 60 days of global delivery service.		3 CO	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.	1/1/2014	12/31/2299
5269	GLOBAL DELIVERY OR C-SECTION NOT ALLOWED IF SEPARATE BILLED.		3 CO	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.	1/1/2014	12/31/2299
5270	TCM-DMR or CHC and DMH services are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5271	HCBS/MR and ADP/MR services are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5272	CHC/CBS and ADP/MR services are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5274	ER PROFESSIONAL SERVICES AND CLINIC VISIT CANNOT BE BILLED ON THE SAME DOS ON T		3 CO	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.	1/1/2014	12/31/2299
5275	CHC and TCM-DMR services are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5276	Skilled nursing and prenatal services are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5277	Surgical visit and abortion or other procedure are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5278	Lens replacement service and frame/lens services are not covered on same DOS.		3 CO	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.	1/1/2014	12/31/2299
5279	Neuropsychological eval and psychodiagnostic tests not covered within 365 days.		3 CO	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.	1/1/2014	12/31/2299
5280	Global delivery and separate delivery/Cesarian cannot be billed separately.		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5282	Fitting of prosthesis and lens/frame service not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5284	Client frame service and other lens/frame service not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5285	Frame replacement service and frame/lens service not allowed on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5286	Brainstem invoked response and CAT scan not covered within 3 months.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
5287	Routine newborn care and critical care are not allowed on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5288	PROFESSIONAL FEE RCC MUST BE BILLED WITH EMERGENCY ROOM RCC		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
5289	Laboratory test included in office visit.		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: 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.	1/1/2014	12/31/2299
5290	LONG-ACTING REVERSIBLE CONTRACEPTIVE DEVICES NOT COVERED WITHOUT ENCOUNTER PROC		3 CO	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.	5/1/2022	12/31/2299
5291	New PT visit not payable within three years of an established patient visit.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
5292	CANNOT HAVE MULTIPLE PRIMARY SURGICAL PROCEDURES ON SAME DATE OFSERVICE.		3 CO	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.	1/1/2014	12/31/2299
5295	LARC REQUIRES INSERTION OR REMOVAL CODE		3 CO	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.	5/1/2022	12/31/2299
5296	PRIMARY ANESTHESIA MUST BE PAID FIRST		3 CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
5298	Periodic exam is not covered within 6 months of initial exam.		3 CO	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.	1/1/2014	12/31/2299
5299	Single first periapical and bitewing/panoramic not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5300	Office visit/consultation and radiology exam are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5301	Only one new exam allowed every 3 years per provider per client.		3 CO	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.	1/1/2014	12/31/2299
5303	Partial dentures are not covered after placement of full upper/lower dentures.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
5304	Home Health visit and CHC screen are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5305	Our records indicate that this tooth has already been extracted.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N431	Not covered with this procedure.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5306	Intraoral and panoramic x-rays are not covered within 24 months of each other.		3 CO	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.	1/1/2014	12/31/2299
5307	First periapical and bitewing/panoramic film are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5308	Alveolar surgery and extractions are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5309	Intraoral/panoramic and bitewing service are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5310	Comprehensive exam and limited exam are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5313	Ophthalmology procedure and office visit not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5314	Laboratory test included in office visit.		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: 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.	1/1/2014	12/31/2299
5316	Duplicate dermatology services are not covered.		3 CO	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.	1/1/2014	12/31/2299
5317	Xrays are included in the procedure.		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: 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.	1/1/2014	12/31/2299
5318	Anesthesia services are not covered.		3 CO	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.	1/1/2014	12/31/2299
5319	PA required for > 1 physical therapy evaluation or check-up in 90 days.		3 CO	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.	1/1/2014	12/31/2299
5320	PA required for > 1 occupational therapy evaluation or check-up in 90 days.		3 CO	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.	1/1/2014	12/31/2299
5321	PA required for more than one hearing evaluation or check-up in 90 days.		3 CO	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.	1/1/2014	12/31/2299
5324	Orthodontic screening and provider screening not allowed by the same provider.		3 CO	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.	1/1/2014	12/31/2299
5325	Neuropsychological eval and psychiatric evaluation not covered within 365 days.		3 CO	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.	1/1/2014	12/31/2299
5327	CHC health screen and clinic visit are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5328	CHC health screen and routine service are not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5331	Basic panel and general health or comp panel not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5332	Electrolyte panel and basic metabolic panel not covered on the same DOS.		3 CO	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.	1/1/2014	12/31/2299
5334	Partial dentures are not covered after placement of full upper/lower dentures.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
5335	Office visit and surgery are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5336	Duplicate dental procedure.		3 CO	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.	1/1/2014	12/31/2299
5337	Outpatient psychiatric services not covered same day as psych/partial hospital.		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5338	OP psychiatric service not covered within 2 days of psych/partial hosp stay.		3 CO	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.	1/1/2014	12/31/2299
5340	PA required for > 1 speech and language evaluation or check-up in 90 days.		3 CO	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.	1/1/2014	12/31/2299
5342	PA required for > 1 speech and hearing evaluation or check-up in 90 days.		3 CO	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.	1/1/2014	12/31/2299
5343	Dental screenings and orthodontic consults not covered for the same provider.		3 CO	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.	1/1/2014	12/31/2299
5344	Dental screening and orthodontic screening are not covered on the same DOS.		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
5345	Home health and CHC services are not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
5346	Mileage is not payable for multiple patient ambulance trips.		3 CO	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.	1/1/2014	12/31/2299
5399	HOSPICE - OTHER COVERED ONLY ON THE SAME DATE OF SERVICE AS EITHER ROUTINE HOSP		3 CO	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.	1/1/2014	12/31/2299
5400	ASSERTIVE COMMUNITY TREATMENT AND RECOVERY ASSISTANT IS NOT COVERED ON THE SAM							1/1/2014	12/31/2299
5401	ASSERTIVE COMMUNITY TREATMENT AND PEER SUPPORTS IS NOT COVERED ON THE SAME DATE		3 CO	B1	Non-covered visits.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
5402	ONLY 1 HOSPICE LEVEL OF CARE ALLOWED PER DATE		3 CO	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.	1/1/2014	12/31/2299
5403	TRANSITIONAL CASE MANAGEMENT NOT COVERED SAME DATE OF SERVICE AS TARGETED CASE		3 CO	B1	Non-covered visits.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
5404	ASSERTIVE COMMUNITY TREATMENT AND COMMUNITY SUPPORT IS NOT COVERED ON THE SAME		3 CO	B1	Non-covered visits.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299
5405	ASSISTIVE LISTENING DEVICE NOT COVERED WITHIN THREE YEARS OF HEARING AID		3 CO	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.	1/1/2014	12/31/2299
5406	MEDICAL ABORTION PROCEDURE INCLUDES ALL ASSOCIATED SERVICES (HCG ULTRASOUND P		4 CO	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.	1/1/2014	12/31/2299
5407	CDT CODE NOT BILLABLE SAME DATE OF SERVICE AS SIMILAR CPT CODE		3 CO	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.	1/1/2014	12/31/2299
5434	SEDATIVE FILLING NOT COVERED FOLLOWING ENDODONTIC PROCEDURE ON SAME TOOTH.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5435	CONSULATION MAY NOT BE BILLED WITH OTHER DIAGNOSTIC CODES		3 CO	11	The diagnosis is inconsistent with the procedure. Usage: 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.	9/4/2014	12/31/2299
5436	A BRIEF OFFICE VISIT FOR DRUG PRESCRIPTIONS USED IN TREATMENT OF MENTAL PSYCHON		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5437	ADJMENT OF GASTRIC BAND DIAMETER IS NOT PAYABLE WITHIN 90 DAYS OF A GASTRIC RES		3 CO	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.	1/1/2014	12/31/2299
5439	INTERPRETATION OF PSYCH/OTHER MEDICAL EXAMS ON SAME DATE DEVELOPMENTAL OR NEURO		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5440	PSYCHIATRIC DIAGNOSTIC INTERVIEW NOT COVERED SAME DATE AS DEVELOPMENTAL /NEURO		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5441	A PSYCHIATRIC DIAGNOSTIC INTERVIEW (INCLUDING INTERACTIVE) IS NOT COVERED ON TH		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5442	PSYCHOLOGICAL TESTING IS NOT COVERED ON THE SAME DATE OF SERVICE AS DEVELOPMEN		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5443	LIMITED DEVELOPMENTAL TESTING IS NOT COVERED ON THE SAME DATE OF SERVICE AS PSY		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5444	EXTENDED DEVELOPMENTAL TESTING IS NOT COVERED ON THE SAME DATE OF SERVICE AS PS		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5445	NEUROPSYCHOLOGICAL TEST NOT COVERED SAME DAY AS PSYCHOLOGICAL/LIMITED/EXTENDED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
5446	URINE DRUG TESTING PROCEDURE INCLUDES ALL ASSOCIATED SERVICES(CREATININE OTHE		3 CO	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.	1/1/2015	12/31/2299
5447	SERVICES FOR RCC 91X SHOULD BE SUBMITTED ON THE SAME CLAIM		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	6/2/2015	12/31/2299
5448	NEMT MILEAGE (S0215) MUST BE BILLED WITH A0426 AND A0428		3 CO	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.	1/1/2016	12/31/2299
5449	GROUND MILEAGE (A0425) MUST BE BILLED WITH A0427 A0429 OR A0100.		3 CO	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.	1/1/2016	12/31/2299
5450	ONLY ONE TARGETED CASE MANAGEMENT CODE BILLED PER MONTH		3 CO	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.	10/1/2015	12/31/2299
5451	CASE-MGT & INT ASSES NC IN SAME CALENDAR MONTH		3 CO	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.	5/20/2016	12/31/2299
5452	THERAPUETIC CGM MONTHLY LIMITATION AUDIT		3 CO	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.	3/1/2020	12/31/2299
5453	DENTAL-GENERAL ANESTHESIA CODE CANNOT BE BILLED ON SAME DAY OF SERVICE WITH COD		3 CO	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.	11/1/2020	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5454	COVID19 ADMIN. MUST BE BILLED WITH COVID19 VACCINE		3 CO	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.	12/11/2020	12/31/2299
5455	COVID 19 LAB ADD ON CODE REPORTED W/O PRIMARY PROC		3 CO	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.	1/1/2021	12/31/2299
5456	E&M ADD ON CODE BILLED W/O PRIMARY CODE		3 CO	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.	1/1/2021	12/31/2299
5457	THERAPUETIC CGM MONTHLY LIMITATION AUDIT		3 CO	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.	6/1/2021	12/31/2299
5458	H0012 & H0014 NOT PAYABLE ON THE SAME DOS		3 CO	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.	11/15/2022	12/31/2299
5460	SERVICE ONLY REIMBURSED SEPARATELY WHEN NON-PATIENT OTHERWISE CONSIDERED PACKA		3 CO	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.	7/1/2016	12/31/2299
5500	CANNOT HAVE MULTIPLE E/M CLAIMS ON THE SAME DATE OF SERVICE.		3 CO	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.	8/1/2015	12/31/2299
5501	CONDITION CODE G0 REQUIRED WHEN MODIFIER 27 BILLED WITH AN E/M CODE		3 CO	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.	8/1/2015	12/31/2299
5502	PREVIOUS CLAIM REQUIRED CONDITION CODE G0 WHEN E/M CODE IS BILLED WITH MODIFIER		3 CO	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.	8/1/2015	12/31/2299
5511	SUSPECT DUPLICATE OF A LAB SERVICE		3 CO	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.	1/1/2014	12/31/2299
5512	SUSPECT DUPLICATE OF AN AMBULATORY SURGICAL CENTER PROCEDURE							1/1/2014	12/31/2299
5520	PROC CODE COMBO REDUCED TO MAX ALLOWED $49.97 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5521	PROC CODE COMBO REDUCED TO MAX ALLOWED $47.47 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5522	PROC CODE COMBO REDUCED TO MAX ALLOWED $64.52 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5523	PROC CODE COMBO REDUCED TO MAX ALLOWED $61.29 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5524	PROC CODE COMBO REDUCED TO MAX ALLOWED $47.82 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5525	PROC CODE COMBO REDUCED TO MAX ALLOWED $55.07 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5526	PROC CODE COMBO REDUCED TO MAX ALLOWED $61.19 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5527	PROC CODE COMBO REDUCED TO MAX ALLOWED $72.43 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5528	PROC CODE COMBO REDUCED TO MAX ALLOWED $68.81 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5529	PROC CODE COMBO REDUCED TO MAX ALLOWED $93.76 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5530	PROC CODE COMBO REDUCED TO MAX ALLOWED $89.07 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5531	PROC CODE COMBO REDUCED TO MAX ALLOWED $70.02 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5532	PROC CODE COMBO REDUCED TO MAX ALLOWED $77.13 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5533	PROC CODE COMBO REDUCED TO MAX ALLOWED $85.70 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5534	PROC CODE COMBO REDUCED TO MAX ALLOWED $102.61 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5535	PROC CODE COMBO REDUCED TO MAX ALLOWED $97.48 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	1/1/2014	12/31/2299
5536	PROC CODE COMBO REDUCED TO MAX ALLOWED $128.21 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	1/1/2014	12/31/2299
5537	PROC CODE COMBO REDUCED TO MAX ALLOWED $121.80 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	1/1/2014	12/31/2299
5538	PROC CODE COMBO REDUCED TO MAX ALLOWED $117.87 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	1/1/2014	12/31/2299
5539	PROC CODE COMBO REDUCED TO MAX ALLOWED $130.97 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	1/1/2014	12/31/2299
5550	OP detox not covered on same or overlapping dates as inpatient services.		3 CO	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.	1/1/2014	12/31/2299
5551	Services not covered on same/overlapping dates of service as inpatient stays.		3 CO	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.	1/1/2014	12/31/2299
5552	Service not covered on same/overlapping date of service as nursing home stay.		3 CO	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.	1/1/2014	12/31/2299
5553	Rental not covered after purchase.		3 CO	108	Rent/purchase guidelines were not met. Usage: 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 returned or after the total of issued rental payments equals the purchase price.	1/1/2014	12/31/2299
5560	PROC CODE COMBO REDUCED TO MAX ALLOWED $51.85 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5561	PROC CODE COMBO REDUCED TO MAX ALLOWED $47.47 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5562	PROC CODE COMBO REDUCED TO MAX ALLOWED $75.15 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5563	PROC CODE COMBO REDUCED TO MAX ALLOWED $68.81 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5564	PROC CODE COMBO REDUCED TO MAX ALLOWED $106.46 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	7/1/2024	12/31/2299
5565	PROC CODE COMBO REDUCED TO MAX ALLOWED $97.48 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5566	PROC CODE COMBO REDUCED TO MAX ALLOWED $66.94OR DENIED BECAUSE BILLED WITHOUT E		3 CO	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.	7/1/2024	12/31/2299
5567	PROC CODE COMBO REDUCED TO MAX ALLOWED $61.29 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5568	PROC CODE COMBO REDUCED TO MAX ALLOWED $97.28 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5569	PROC CODE COMBO REDUCED TO MAX ALLOWED $89.07 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5570	PROC CODE COMBO REDUCED TO MAX ALLOWED $133.02 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	7/1/2024	12/31/2299
5571	PROC CODE COMBO REDUCED TO MAX ALLOWED $121.80 OR DENIED BECAUSE BILLED WITHOU		3 CO	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.	7/1/2024	12/31/2299
5572	PROC CODE COMBO REDUCED TO MAX ALLOWED $49.61OR DENIED BECAUSE BILLED WITHOUT E		3 CO	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.	7/1/2024	12/31/2299
5573	PROC CODE COMBO REDUCED TO MAX ALLOWED $47.82 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5574	PROC CODE COMBO REDUCED TO MAX ALLOWED $72.65 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299
5575	PROC CODE COMBO REDUCED TO MAX ALLOWED $70.02 OR DENIED BECAUSE BILLED WITHOUT		3 CO	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.	7/1/2024	12/31/2299

EOB	EOB Description	Business Scenario		CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
5576	PROC CODE COMBO REDUCED TO MAX ALLOWED $57.14 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5577	PROC CODE COMBO REDUCED TO MAX ALLOWED $55.07 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5578	PROC CODE COMBO REDUCED TO MAX ALLOWED $80.02 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5579	PROC CODE COMBO REDUCED TO MAX ALLOWED $77.13 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5580	PROC CODE COMBO REDUCED TO MAX ALLOWED $122.29 OR DENIED BECAUSE BILLED WITHOU			3 CO	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.	7/1/2024	12/31/2299
5581	PROC CODE COMBO REDUCED TO MAX ALLOWED $117.87 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5582	PROC CODE COMBO REDUCED TO MAX ALLOWED $63.49 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5583	PROC CODE COMBO REDUCED TO MAX ALLOWED $61.19 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5584	PROC CODE COMBO REDUCED TO MAX ALLOWED $88.91 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5585	PROC CODE COMBO REDUCED TO MAX ALLOWED $85.70 OR DENIED BECAUSE BILLED WITHOUT			3 CO	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.	7/1/2024	12/31/2299
5586	PROC CODE COMBO REDUCED TO MAX ALLOWED $135.88 OR DENIED BECAUSE BILLED WITHOU			3 CO	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.	7/1/2024	12/31/2299
5587	PROC CODE COMBO REDUCED TO MAX ALLOWED $130.97 OR DENIED BECAUSE BILLED WITHOU			3 CO	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.	7/1/2024	12/31/2299
5650 Start: 07/15/2013	REPRICED DUE TO MULTIPLE SURGERY PRICING METHODOLOGY.	1/1/2014	12/31/2299	3 CO	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.		
5661	INVALID BILLING OF MODIFIER GD			3 CO	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.	7/1/2016	12/31/2299
5665	INVALID BILLING OF MODIFIER GD			3 CO	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.	7/1/2016	12/31/2299
5924	CLAIM DENIED CCI GREATER AND LESSER PROCEDURES ARE NOT COVERED ON SAME DATE O			3 CO	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.	1/1/2014	12/31/2299
5925	CCI COLUMN 1 CODE OR MUTUALLY EXCLUSIVE CODE WAS BILLED ON THE SAME DATE AS PRE			3 CO	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.	1/1/2014	12/31/2299
5926	CCI COLUMN 2 CODE WAS BILLED ON THE SAME DATE AS PREVIOUS COLUMN 1 OR MUTUALLY			3 CO	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.	1/1/2014	12/31/2299
5927	CODE2 OF A CODE PAIR THAT IS NOT ALLOWED BY NCCI EVEN IF APPROPRIATE MODIFIER I			3 CO	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.	7/1/2016	12/31/2299
5928	CODE2 OF A CODE PAIR THAT WOULD BE ALLOWED BY NCCI IF APPROPRIATE MODIFIER WERE			3 CO	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.	7/1/2016	12/31/2299
5950	HOSPITAL RESERVE CANNOT EXCEED 15 DAYS/ DISCHARGE			3 CO	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.	1/1/2014	12/31/2299
6000	SUSPENDED MANUALLY PRICED CLAIM CURRENTLY UNDER REVIEW.			1 CO	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).	M23	Missing invoice.	9/5/2015	12/31/2299
6001	End stage renal disease daily codes limited to one per day.			3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6002	End stage renal disease daily codes limited to one per day.		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
6003	Personal services are limited to one per day.		3 CO	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.	1/1/2014	12/31/2299
6004	PA required for more than 14 dialysis treatments per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6005	End stage renal disease monthly codes are limited to one per month.		3 CO	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.	1/1/2014	12/31/2299
6006	Only 96 Personal Care Assistance units allowed per date of service.		3 CO	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.	1/1/2014	12/31/2299
6007	Prior authorization required for more than 1 evaluation per calendar year.		3 CO	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.	1/1/2014	12/31/2299
6008	Personal response system limited to two per month.		3 CO	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.	1/1/2014	12/31/2299
6009	Substance abuse program limited to 56 days per year.		3 CO	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.	1/1/2014	12/31/2299
6010	ABI procedure exceeded $10 000 per year maximum.		3 CO	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.	1/1/2014	12/31/2299
6012	ABI services limited to 40 hours per week.		3 CO	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.	1/1/2014	12/31/2299
6013	Purchase of feeding pump is limited to one per three years.		3 CO	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.	1/1/2014	12/31/2299
6014	Purchase of feeding tubes are limited to one per day.		3 CO	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.	1/1/2014	12/31/2299
6015	Limit of one infusion pump per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6016	Purchase of parenteral infusion pumps are limited to one per three years.		3 CO	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.	1/1/2014	12/31/2299
6017	PA required for rental after 3 months of continuous rental by same provider.		3 CO	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.	1/1/2014	12/31/2299
6018	Only one enteral feeding or parenteral nutrition supply kit per day.		3 CO	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.	1/1/2014	12/31/2299
6020	Transitional living services limited to 183 days per client lifetime.		3 CO	35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	1/1/2014	12/31/2299
6021	PA required for more than 86 treatment services per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6022	PA required for more than 90 treatments per calendar year with diagnosis.		3 CO	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.	1/1/2014	12/31/2299
6023	Purchase of IV poles is limited to 3 per year.		3 CO	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.	1/1/2014	12/31/2299
6024	PA required for more than 1 evaluation in 365 days.		3 CO	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.	1/1/2014	12/31/2299
6026	1 initial pers service allowed per client per billing and performing provider.		3 CO	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.	1/1/2014	12/31/2299
6027	CHC mental health counseling limited to 1 per provider/client/date of service.		3 CO	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.	1/1/2014	12/31/2299
6028	Meal service limited to 1 per date of service.		3 CO	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.	1/1/2014	12/31/2299
6029	Only 1 pers service allowed per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6030	MAXIMUM OF 25 HOURS OF NUTRITIONAL COUNSELING PER 365 DAYS		3 CO	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.	9/1/2017	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6032	PA required for more than 5 occupational therapy visits per month.		3 CO	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.	1/1/2014	12/31/2299
6033	PA required for > 9 occupational therapy visits per cal year with diagnosis.		3 CO	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.	1/1/2014	12/31/2299
6034	PA required for more than 10 speech therapy visits per month.		3 CO	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.	1/1/2014	12/31/2299
6035	PA required for more than 9 speech therapy visits per cal year with diagnosis.		3 CO	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.	1/1/2014	12/31/2299
6036	PA required for more than 10 hearing therapy visits per month.		3 CO	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.	1/1/2014	12/31/2299
6037	PA required for more than 9 hearing therapy visits per cal year with diagnosis.		3 CO	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.	1/1/2014	12/31/2299
6040	Adult day care services are limited to one per day.		3 CO	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.	1/1/2014	12/31/2299
6041	Adult day care services are limited to one per day.		3 CO	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.	1/1/2014	12/31/2299
6042	Homemaker services limited to 96 units per date of service.		3 CO	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.	1/1/2014	12/31/2299
6043	Homemaker services limited to 96 units per date of service.		3 CO	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.	1/1/2014	12/31/2299
6044	Only one primary care code per provider per client per date of service allowed.		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
6045	Only one primary care code per provider per client per date of service allowed.		3 CO	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.	1/1/2014	12/31/2299
6049	Exceeds maximum of 9 screens per client age 5 - 21.		3 CO	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.	1/1/2014	12/31/2299
6050	Exceeds maximum of 9 clinic screens per client age 5 - 21.		3 CO	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.	9/1/2017	12/31/2299
6051	Exceeds maximum of 9 home health screens per client age 5 - 21.		3 CO	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.	1/1/2014	12/31/2299
6052	Only 3 developmental screens per client per provider per 365 days.		3 CO	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.	1/1/2014	12/31/2299
6053	Exceeds maximum of 11 screens per client age 0 - 4.		3 CO	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.	1/1/2014	12/31/2299
6054	EXCEEDS MAXIMUM OF 15 CLINIC SCREENS PER CLIENT AGE 0 - 4.		3 CO	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.	1/1/2014	12/31/2299
6055	Exceeds maximum of 11 home health screens per client age 0 - 4.		3 CO	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.	1/1/2014	12/31/2299
6056	PA required for more than 13 individual therapy visits in 90 days.		3 CO	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.	1/1/2014	12/31/2299
6057	Environmental adaptations limited to $30 000 per calendar year.		3 CO	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.	1/1/2014	12/31/2299
6058	Only two units of equipment allowed per calendar year.		3 CO	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.	1/1/2014	12/31/2299
6059	ONLY 3 HEARINGS PER CLIENT PER PROVIDER PER YEAR.		3 CO	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.	1/1/2014	12/31/2299
6060	CHESS SERVICE LIMITED TO 1 000.00 PER YEAR		3 CO	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.	8/16/2021	12/31/2299
6062	ONLY 3 INTERPERIOD VISION PER CLIENT PER PROVIDER PER YEAR.		3 CO	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.	1/1/2014	12/31/2299
6065	Only 90 days of facility based respite care per calendar year.		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6066	Only one respite service per month.		3 CO	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.	1/1/2014	12/31/2299
6067	PA required for more than 13 group therapy visits in 90 days.		3 CO	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.	1/1/2014	12/31/2299
6069	MORE THAN 1 UNIT PER PROCEDURE PER PROVIDER PER CLIENT SHOULD FOLLOW MULTIPLE S		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	1/1/2014	12/31/2299
6071	Claim for assistant surgeon services was manually priced.							1/1/2014	12/31/2299
6072	Only one new exam allowed every 3 years per provider per client.		3 CO	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.	1/1/2014	12/31/2299
6073	Only 1 dental visit to a client in a nursing facility allowed per 365 days.		3 CO	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.	1/1/2014	12/31/2299
6078	Exceeds limit of 9 screens allowed for ages 6 - 21.							1/1/2014	12/31/2299
6079	Exceeds limit of 6 screens allowed for ages 2 - 6.							1/1/2014	12/31/2299
6080	Exceeds limit of 5 screens allowed for ages 1 - 2.							1/1/2014	12/31/2299
6081	Exceeds limit of 6 screens allowed for ages 0 - 1.		3 CO	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.	1/1/2014	12/31/2299
6084	PA REQUIRED FOR MORE THAN 2 PHYSICAL THERAPY VISITS PER 7 DAYS.		3 CO	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.	1/1/2014	12/31/2299
6085	PRIOR AUTHORIZATION REQUIRED FOR MORE THAN 1 CASE MANAGEMENT PER MONTH.		3 CO	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.	1/1/2014	12/31/2299
6088	PA required for more than 13 family therapy visits in 90 days.		3 CO	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.	1/1/2014	12/31/2299
6090	Surgical procedure with this place of service requires PA.		3 CO	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.	1/1/2014	12/31/2299
6092	PA required for more than two clinic therapy services per calendar week.		3 CO	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.	1/1/2014	12/31/2299
6093	PA required > 9 clinic therapy services per calendar year for diagnosis code.		3 CO	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.	1/1/2014	12/31/2299
6094	PA required for more than two podiatry therapy services per calendar week.		3 CO	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.	1/1/2014	12/31/2299
6095	PA required for more than 4 podiatry therapy services per calendar week.		3 CO	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.	1/1/2014	12/31/2299
6096	PA required > 9 home health therapy services per cal year for diagnosis code.		3 CO	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.	1/1/2014	12/31/2299
6097	PA required for > 2 Speech/Audiology therapy services per calendar week.		3 CO	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.	1/1/2014	12/31/2299
6098	PA required for more than two therapy services per calendar week.		3 CO	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.	1/1/2014	12/31/2299
6099	PA required for more than two visits per 365 days.		3 CO	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.	1/1/2014	12/31/2299
6100	PA required > 9 podiatry therapy services per calendar year for diagnosis code.		3 CO	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.	1/1/2014	12/31/2299
6101	PA required > 9 speech/audiology services per cal yr for diagnosis code.		3 CO	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.	1/1/2014	12/31/2299
6102	Exceeds limit of one unit per date of service.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
6103	PA required for more than 1 clinic therapy service per calendar week.		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6104	Only 1 neuropsychological evaluation allowed per year.		3 CO	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.	1/1/2014	12/31/2299
6105	PA required for fluoride treatment if 21 years or older.		3 CO	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.	1/1/2014	12/31/2299
6106	PA required > 9 physical therapy visits per calendar year with diagnosis code.		3 CO	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.	1/1/2014	12/31/2299
6107	PA required for > 90 treatment services per year with specific diagnosis.		3 CO	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.	1/1/2014	12/31/2299
6108	Only 5 podiatry visits allowed per client per provider per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6109	PA is required for more than two visits per 365 days.		3 CO	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.	1/1/2014	12/31/2299
6110	Only one panoramic x-ray is covered per 36 months.		3 CO	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.	1/1/2014	12/31/2299
6112	PA required for more than 86 treatment services per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6113	ONLY ONE EXAMINATION CODE ALLOWED PER DAY		3 CO	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.	1/1/2014	12/31/2299
6114	Only one CHC health screen can be performed on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
6115	Only one tooth sealant in 5 years per client and per tooth allowed.		3 CO	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.	1/1/2014	12/31/2299
6116	Only one bitewing procedure allowed within a six month period.		3 CO	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.	1/1/2014	12/31/2299
6117	Exceeds limit of one denture per 5 years.		3 CO	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.	1/1/2014	12/31/2299
6118	Only one dental prophylaxis allowed per six months.		3 CO	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.	1/1/2014	12/31/2299
6119	Only one periodic oral exam allowed per six months.		3 CO	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.	1/1/2014	12/31/2299
6120	Only one initial oral exam allowed per 3 years.		3 CO	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.	1/1/2014	12/31/2299
6121	Hearing test is only allowed when billed with hearing instrument.		3 CO	272	Coverage/program guidelines were not met.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	5/1/2016	12/31/2299
6122	Records show that a fluoride treatment has been billed in the past 6 months.		3 CO	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.	1/1/2014	12/31/2299
6123	Exceeds limit of one upper partial per 5 years.		3 CO	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.	1/1/2014	12/31/2299
6124	Exceeds limit of one lower partial per 5 years.		3 CO	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.	1/1/2014	12/31/2299
6126	Only one electromyography procedure allowed per date of service.		3 CO	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.	1/1/2014	12/31/2299
6127	DME purchase limited to one per lifetime.							1/1/2014	12/31/2299
6129	Space shoes are limited to 1 per 3 years.		3 CO	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.	1/1/2014	12/31/2299
6131	Hepatitis B immunization limited to 3 times per lifetime.		3 CO	35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	1/1/2014	12/31/2299
6133	PA required for more than 13 therapy services in 90 days.		3 CO	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.	1/1/2014	12/31/2299
6134	PA required for more than 26 therapy services in 6 months.		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6135	Only one Nursing Home status review per 45 days.		3 CO	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.	1/1/2014	12/31/2299
6138	More than one visit with client on the same date of service requires PA.		3 CO	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.	1/1/2014	12/31/2299
6141	PA is required for more than 12 skilled nursing visits per month.		3 CO	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.	1/1/2014	12/31/2299
6145	Exceeds limit of one per 2 years.		3 CO	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.	1/1/2014	12/31/2299
6146	Meal service limited to 1 per date of service.		3 CO	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.	1/1/2014	12/31/2299
6147	Only one pers service allowed per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6148	Only one restoration per tooth surface allowed per year.		3 CO	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.	1/1/2014	12/31/2299
6149	Evaluations are limited to one per year.		3 CO	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.	1/1/2014	12/31/2299
6150	Only 2 consultations are allowed per provider per client per year.		3 CO	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.	1/1/2014	12/31/2299
6153	Psychological evaluations are limited to one per year.		3 CO	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.	1/1/2014	12/31/2299
6155	PA required for more than one evaluation per year.		3 CO	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.	1/1/2014	12/31/2299
6156	Exceeds maximum of one visit per week.		3 CO	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.	1/1/2014	12/31/2299
6158	PA rquired for more than 12 nurse visits per month.		3 CO	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.	1/1/2014	12/31/2299
6159	Home Health aide units exceed policy requirements.		3 CO	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.	1/1/2014	12/31/2299
6160	PRIOR AUTHORIZATION REQUIRED MORE THAN 13 THERAPY SERVICES PER 90 DAYS		3 CO	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.	1/1/2014	12/31/2299
6161	PRIOR AUTHORIZATION REQUIRED FOR MORE THAN 2 THERAPY VISITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6163	Only one skilled nursing evaluation allowed per year.		3 CO	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.	1/1/2014	12/31/2299
6164	PA required for more than 13 therapy or child guidance visits in 90 days.							1/1/2014	12/31/2299
6165	PA required for more than 26 therapy or child guidance visits in 6 months.							1/1/2014	12/31/2299
6166	Only one clinic visit allowed per day per client per provider.		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
6168	Psychotherapy performed in SNF/ICF requires PA.		3 CO	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.	1/1/2014	12/31/2299
6169	Mental health counseling limited to 1 per provider/client/date of service.		3 CO	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.	1/1/2014	12/31/2299
6171	Respite care limited to 720 hours per 365 days.		3 CO	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.	1/1/2014	12/31/2299
6172	Only one status review allowed per 30 days.		3 CO	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.	1/1/2014	12/31/2299
6173	Only one joint or initial assessment per 60 days.		3 CO	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.	1/1/2014	12/31/2299
6174	1 initial pers service allowed per client per billing and performing provider.		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6177	Only one orthodontic consult per client's lifetime.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N117	This service is paid only once in a patient's lifetime.	1/1/2014	12/31/2299
6178	Only one preliminary orthodontic assessment per client's lifetime.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N117	This service is paid only once in a patient's lifetime.	1/1/2014	12/31/2299
6179	End stage renal disease monthly codes are limited to one per month.		3 CO	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.	1/1/2014	12/31/2299
6181	Only one visit per day per revenue center code is allowed.		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
6182	ICF/MR home reserve days billed exceeds the maximum of 36 days per year.		3 CO	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.	1/1/2014	12/31/2299
6183	Home reserve days billed exceeds the maximum of 21 days per year.		3 CO	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.	1/1/2014	12/31/2299
6184	Procedure requires prior authorization.		3 CO	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.	1/1/2014	12/31/2299
6185	Procedure requires prior authorization.		3 CO	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.	1/1/2014	12/31/2299
6186	Complex visit requires PA.		3 CO	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.	1/1/2014	12/31/2299
6187	Only 3 units of non-sterile gloves allowed per day.		3 CO	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.	1/1/2014	12/31/2299
6188	Only one DMH-TCM service allowed per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6189	Only one psychotherapy w/medical evaluation & management allowed per DOS.		3 CO	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.	1/1/2014	12/31/2299
6190	Only one psychotherapy w/medical evaluation & management allowed per DOS.		3 CO	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.	1/1/2014	12/31/2299
6191	ONE PHARMACOLOGIC MANAGEMENT VISIT PER DAY.		3 CO	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.	1/1/2014	12/31/2299
6193	Only one biopsy per day allowed.		3 CO	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.	1/1/2014	12/31/2299
6194	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6195	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6196	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6197	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6198	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6199	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6200	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6201	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6202	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6203	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6204	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6205	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6206	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6207	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6208	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6209	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6210	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6211	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6212	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6213	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6214	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6215	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6216	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6217	Duplicate of a service paid		3 CO	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.	1/1/2014	12/31/2299
6218	Only one equipment service per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6219	Only one targeted case management service per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6220	Only one service bundle allowed per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6221	Only one evaluation allowed per calendar month.		3 CO	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.	1/1/2014	12/31/2299
6222	PA required after 3 months of rental.		3 CO	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.	1/1/2014	12/31/2299
6223	DME service with facility type code of 31 or 32 requires PA.		3 CO	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.	1/1/2014	12/31/2299
6224	Medical management and psychotherapy not covered on the same date of service.		3 CO	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.	1/1/2014	12/31/2299
6225	Complex visit requires PA.		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6226	Preventative counseling limited to one per day.		3 CO	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.	1/1/2014	12/31/2299
6227	Preventative medicine counseling limited to one per day.		3 CO	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.	1/1/2014	12/31/2299
6228	Audiologic function test limited to $115.12 per 365 days.		3 CO	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.	1/1/2014	12/31/2299
6229	PA required for more than 2 nursing visits per week.		3 CO	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.	1/1/2014	12/31/2299
6230	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6231	PA required for > 2 services per year for Behavioral Health Partnership.		3 CO	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.	1/1/2014	12/31/2299
6232	PA REQUIRED MORE THAN 12 SERVICES PER YEAR FOR BEHAVIORAL HEALTH PARTNERSHIP.		3 CO	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.	1/1/2014	12/31/2299
6233	PA REQUIRED FOR MORE THAN 56 AIDE UNITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6234	PLAN OF CARE EXCEEDED OR PA REQUIRED > 56 UNITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6235	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 PT/ST VISITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6236	PLAN OF CARE EXCEEDED OR PA REQUIRED > 1 OT VISIT PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6237	PLAN OF CARE EXCEEDED OR PA REQUIRED > 5 NURSE VISITS PER WEEK		3 CO	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.	4/1/2020	12/31/2299
6238	PLAN OF CARE EXCEEDED OR PA REQUIRED > 4 PT/ST VISITS PER WEEK		3 CO	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.	4/1/2020	12/31/2299
6239	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 OT VISIT PER WEEK		3 CO	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.	4/1/2020	12/31/2299
6240	PLAN OF CARE EXCEEDED OR PA REQUIRED > 5 NURSE VISITS PER WEEK		3 CO	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.	4/1/2020	12/31/2299
6250	DENTAL ANNUAL BENEFIT MAXIMUM EXCEEDED		3 PR	273	Coverage/program guidelines were exceeded.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	7/1/2017	12/31/2299
6251	FQHC PERIODIC DENTAL VISIT MUST BE PERFORMED IN A SINGLE VISIT		3 CO	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.	7/1/2022	12/31/2299
6252	PA REQUIRED FOR >THAN 24 HRS (96 UNITS) PER YR BHP		3 CO	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.	1/1/2023	12/31/2299
6253	3 UNITS OF T2024 ALLOWED IN A 12 MONTH PERIOD		3 CO	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.	3/1/2022	12/31/2299
6290	HOSPICE RN-SW SERVICES ARE LIMITED TO 16 UNITS PER DAY		3 CO	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.	1/1/2016	12/31/2299
6300	QUANTITY LIMITATION 1 PER 2 YEARS		3 CO	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.	7/1/2021	12/31/2299
6301	QUANTITY LIMITATION 1 PER 3 YEARS		3 CO	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.	7/1/2021	12/31/2299
6302	QUANTITY LIMITATION 1 PER 5 YEARS		3 CO	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.	7/1/2021	12/31/2299
6303	QUANTITY LIMITATION 1 PER YEAR		3 CO	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.	7/1/2021	12/31/2299
6304	QUANTITY LIMITATION 2 PER YEAR		3 CO	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.	7/1/2021	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6305	QUANTITY LIMITATION 220 PER MONTH		3 CO	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.	7/1/2021	12/31/2299
6306	QUANTITY LIMITATION 3 PER YEAR		3 CO	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.	7/1/2021	12/31/2299
6307	QUANTITY LIMITATION 4 PER YEAR		3 CO	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.	7/1/2021	12/31/2299
6308	QUANTITY LIMITATION 6 PER MONTH		3 CO	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.	7/1/2021	12/31/2299
6309	QUANTITY LIMITATION 6 PER YEAR		3 CO	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.	7/1/2021	12/31/2299
6310	QUANTITY LIMITATION 1 PER 6 MONTHS		3 CO	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.	7/1/2021	12/31/2299
6311	1 SET OF DIAGNOSTIC CASTS PER LIFETIME		3 CO	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.	8/1/2021	12/31/2299
6312	2 SETS OF DIAGNOSTIC CASTS PER LIFTIME		3 CO	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.	8/1/2021	12/31/2299
6313	3 SET OF DIAGNOSTIC CASTS/DIGITAL MODELS PER LIFETIME		3 CO	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.	8/1/2021	12/31/2299
6314	1 SET OF DIAGNOSTIC CASTS/DIGITAL MODELS PER LIFTIME		3 CO	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.	8/1/2021	12/31/2299
6315	QUANTITY LIMITATION 2 PER 2 YEARS		3 CO	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.	7/1/2021	12/31/2299
6316	QUANTITY LIMITATION 2 PER 3 YEARS		3 CO	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.	7/1/2021	12/31/2299
6317	QUANTITY LIMITATION 4 PER YEAR		3 CO	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.	7/1/2021	12/31/2299
6318	QUANTITY LIMITATION 8 PER YEAR		3 CO	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.	7/1/2021	12/31/2299
6400	TOTAL NON-MEDICAL TRANSPORTATION SERVICES LIMITED TO $1 000 PER CALENDAR YEAR.		3 CO	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.	1/1/2014	12/31/2299
6401	PA REQUIRED FOR MORE THAN 2 PT VISITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6402	PA REQUIRED FOR MORE THAN 1 OT VISITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6403	PA REQUIRED FOR MORE THAN 9 OT VISITS PER CALENDAR YEAR FOR DIAGNOSIS		3 CO	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.	1/1/2014	12/31/2299
6404	PA REQUIRED FOR MORE THAN 2 SPEECH THERAPY VISITS PER WEEK.		3 CO	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.	1/1/2014	12/31/2299
6405	PA REQUIRED FOR MORE THAN 9 SPEECH THERAPY VISITS PER CALENDAR YEAR FOR DIAGNOS		3 CO	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.	1/1/2014	12/31/2299
6406	PA REQUIRED FOR MORE THAN 2 AUDIOLOGY VISITS PER WEEK.		3 CO	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.	1/1/2014	12/31/2299
6407	PA REQUIRED FOR MORE THAN 9 AUDIOLOGY VISITS PER CALENDAR YEAR WITH DIAGNOSIS.		3 CO	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.	1/1/2014	12/31/2299
6408	2 CONSULTATIONS ARE ALLOWED PER YEAR PER PROVIDER		3 CO	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.	1/1/2014	12/31/2299
6409	1 CONSULTATION ALLOWED PER 30 DAYS PER PROVIDER		3 CO	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.	1/1/2014	12/31/2299
6410	PA REQUIRED FOR MORE THAN 5 DAYS OF GENERAL INPATIENT HOSPICE CARE IN A HOSPITA		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6411	ONLY 5 DAYS OF RESPITE CARE IN A NF OR HOSPITAL IS ALLOWED IN ANY 60 DAY PERIOD		3 CO	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.	1/1/2014	12/31/2299
6412	PROCEDURE LIMITED TO ONCE PER LIFETIME PER TOOTH		3 CO	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.	1/1/2014	12/31/2299
6413	PROCEDURE LIMITED TO THREE PER LIFETIME		3 CO	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.	1/1/2014	12/31/2299
6414	TWO EYEGLASS LENSES PER 365 DAYS.		3 CO	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.	1/1/2014	12/31/2299
6415	ONE EYEGLASS FRAME PER YEAR PER CLIENT		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	1/1/2014	12/31/2299
6416	LIMIT THE REIMBURSEMENT FOR SPECTACLE FITTINGS TO ONE UNIT PER CLIENT PER 365 D		3 CO	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.	1/1/2014	12/31/2299
6417	ASSISTIVE TECHN LIMITED TO $1000.00 PER YEAR		3 CO	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.	1/1/2014	12/31/2299
6418	ONLY ONE UNIT OF TARGETED CASE MANAGEMENT ALLOWED PER WEEK EFFECTIVE 11/01/2010		3 CO	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.	1/1/2014	12/31/2299
6419	PLAN OF CARE EXCEEDED OR PA REQUIRED > 56 UNITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6420	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6422	ONLY ONE FAMILY PSYCHOTHERAPY PAYABLE PER DAY		3 CO	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.	1/1/2014	12/31/2299
6423	ONLY ONE GROUP PSYCHOTHERAPY PAYABLE PER DAY		3 CO	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.	1/1/2014	12/31/2299
6424	ONLY ONE INDIVIDUAL PSYCHOTHERAPY PAYABLE PER DAY		3 CO	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.	1/1/2014	12/31/2299
6425	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 6 MONTHS FOR CLIENTS 20 AND UNDER		3 CO	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.	1/1/2014	12/31/2299
6426	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 12 MONTHS FOR CLIENTS 21 AND OVER		3 CO	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.	1/1/2014	12/31/2299
6427	COMPREHENSIVE ORAL EVALUATION LIMITED TO ONCE PER 3 YEARS WHEN UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6428	COMPREHENSIVE EVALUATION LIMITED TO ONCE CLIENT'S LIFETIME WHEN 21 AND OLDER		3 CO	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.	1/1/2014	12/31/2299
6429	1 BITEWING PROCEDURE ALLOWED PER SIX MONTHS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6430	4 PERIAPICAL RADIOGRAPHS ALLOWED PER 12 MONTHS FOR CLIENTS 21 AND OVER.		3 CO	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.	1/1/2014	12/31/2299
6431	ONLY 1 BITEWING RADIOGRAPH ALLOWED PER YEAR FOR CLIENTS 21 AND OVER		3 CO	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.	1/1/2014	12/31/2299
6432	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER YEAR FOR CLIENTS 21 AND OVER		3 CO	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.	1/1/2014	12/31/2299
6433	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER SIX MONTHS FOR CLIENTS 20 AND UNDER.		3 CO	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.	1/1/2014	12/31/2299
6434	EXCEEDS LIMIT OF ONE DENTURE PER 5 YEARS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6435	EXCEEDS LIMIT OF 1 DENTURE PER 7 YEARS FOR CLIENTS 21 AND OVER		3 CO	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.	1/1/2014	12/31/2299
6436	1 UPPER PARTIAL PER 5 YEARS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6437	1 UPPER PARTIAL PER 7 YEARS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6438	1 LOWER PARTIAL PER 5 YEARS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6439	1 LOWER PARTIAL PER 7 YEARS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6440	SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES LIMITED TO $2 500.00 PER YEAR FOR ED		3 CO	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.	1/1/2014	12/31/2299
6441	INDIVIDUAL GOODS AND SERVICES LIMITED TO $6 000.00 PER YEAR FOR EDS WAIVER.		3 CO	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.	1/1/2014	12/31/2299
6442	HEARING AID COVERAGE LIMITED TO $1000 EVERY 24 MONTHS FOR HUSKY B CLIENTS		3 CO	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.	1/1/2014	12/31/2299
6443	HUSKY B EYEGLASS/CONTACT COVERAGE LIMITED TO $100 EVERY 2 CALENDAR YEARS		3 CO	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.	1/1/2014	12/31/2299
6444	HUSKY B NURSING HOME COVERAGE LIMITED TO 60 DAYS		3 CO	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.	1/1/2014	12/31/2299
6445	CHOAK LIMITED TO ONE WELL VISIT PER YEAR		3 CO	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.	1/1/2014	12/31/2299
6446	CHOAK LIMITED TO ONE EYE EXAM PER YEAR		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	1/1/2014	12/31/2299
6447	QUANTITY LIMITATIONS PER CALENDAR MONTHS MED SURGE SUPPLIES - LIMIT OF 1		3 CO	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.	1/1/2014	12/31/2299
6448	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 2		3 CO	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.	1/1/2014	12/31/2299
6449	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 4		3 CO	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.	1/1/2014	12/31/2299
6450	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 8		3 CO	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.	1/1/2014	12/31/2299
6451	QUANTITY LIMITATION PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 16		3 CO	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.	1/1/2014	12/31/2299
6452	QUANTITY LIMITATION PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 31		3 CO	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.	1/1/2014	12/31/2299
6453	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 60		3 CO	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.	1/1/2014	12/31/2299
6454	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 100		3 CO	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.	1/1/2014	12/31/2299
6455	QUANTITY LIMITATION PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 150		3 CO	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.	1/1/2014	12/31/2299
6456	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 200		3 CO	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.	1/1/2014	12/31/2299
6457	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 250		3 CO	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.	1/1/2014	12/31/2299
6458	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 300		3 CO	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.	1/1/2014	12/31/2299
6459	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 500		3 CO	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.	1/1/2014	12/31/2299
6460	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES LIMIT OF 2 WITH MODI		3 CO	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.	1/1/2014	12/31/2299
6461	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES LIMIT OF 2 EXCLUDE M		3 CO	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.	1/1/2014	12/31/2299
6462	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 1 QTY WITH MODIFIE		3 CO	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.	1/1/2014	12/31/2299
6463	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 1 EXCLUDE MODIFIER		3 CO	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.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6464	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 4 QTY WITH MODIFIE		3 CO	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.	1/1/2014	12/31/2299
6465	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 4 QTY EXCLUDE MODI		3 CO	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.	1/1/2014	12/31/2299
6466	LIVE-IN CAREGIVER SERVICE LIMITED TO $600.00 PER MONTH		3 CO	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.	1/1/2014	12/31/2299
6467	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 20		3 CO	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.	1/1/2014	12/31/2299
6468	TARGETED CASE MANAGEMENT IS A WEEKLY SERVICE		3 CO	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.	1/1/2014	12/31/2299
6469	BIRTHING CENTER RCC LIMIT 1 PER PREGNANCY		3 CO	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.	1/1/2014	12/31/2299
6470	RECORDS SHOW THAT A FLUORIDE TREATMENT HAS BEEN BILLED IN THE PAST 6 MONTHS.		3 CO	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.	1/1/2014	12/31/2299
6471	1 BITEWING PROCEDURE ALLOWED PER SIX MONTHS FOR CLIENTS UNDER 21		3 CO	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.	1/1/2014	12/31/2299
6472	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 6 MONTHS FOR CLIENTS 20 AND UNDER		3 CO	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.	1/1/2014	12/31/2299
6473	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER SIX MONTHS FOR CLIENTS 20 AND UNDER.		3 CO	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.	1/1/2014	12/31/2299
6477	QUANTITY LIMITATIONS PER 365 DAYS - PROSTHETIC SUPPLIES LIMIT OF TWO		3 CO	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.	1/1/2014	12/31/2299
6480	CHOAK LIMITED TO ONE EYE EXAM PER YEAR		3 CO	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.	1/1/2014	12/31/2299
6481	LIMIT OF 2 PAIRS OF SHOES PER CALENDAR YEAR		3 CO	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.	1/1/2014	12/31/2299
6482	AUTISM SERVICE 1 UNIT PER MONTH		3 CO	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.	1/1/2014	12/31/2299
6483	ASSISTIVE TECHNOLOGY LIMITED TO $5000 PER 5 YEARS		3 CO	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.	1/1/2014	12/31/2299
6484	SPERMICIDE LIMIT TO 1 PER MONTH		3 CO	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.	1/1/2014	12/31/2299
6485	FEMALE CONDOMS LIMITED TO 30 PER MONTH		3 CO	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.	1/1/2014	12/31/2299
6486	MALE CONDOMS LIMITED TO 36 PER MONTH		3 CO	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.	1/1/2014	12/31/2299
6487	AUDIOLOGY EVALUATION LIMIT TO 1 (4 UNITS) PER CALENDAR YEAR		3 CO	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.	1/1/2014	12/31/2299
6488	PA REQUIRED FOR MORE THAN ONE AUDIOLOGY EVALUATION PER CALENDAR YEAR.		3 CO	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.	1/1/2014	12/31/2299
6489	PA REQ MORE THAN 1 OCCUPATIONAL THERAPY PER WEEK		3 CO	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.	1/1/2014	12/31/2299
6490	ONE EVALUATION PER CALENDAR YEAR WITHOUT PA		3 CO	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.	1/1/2014	12/31/2299
6491	ONE EVALUATION PER CALENDAR YEAR WITHOUT PA		3 CO	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.	1/1/2014	12/31/2299
6492	MODIFICATIONS TO DIABETIC SHOES LIMITED TO 4 UNITS PER CALENDAR YR		3 CO	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.	1/1/2014	12/31/2299
6493	LIMIT TO $5000 PER CALENDAR YEAR		3 CO	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.	1/1/2014	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6494	1 VISIT PER CLIENT PER PROV PER DATE OF SERVICE		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
6495	1 OFFICE VISIT PER CLIENT PER PROV PER DATE OF SERVICE		3 CO	B14	Payment denied because 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.	1/1/2014	12/31/2299
6496	PERIODIC ORAL EVALUATION LIMITED TO 2 PER 12 MONTHS FOR CLIENTS 21 AND OVER		3 CO	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.	1/1/2014	12/31/2299
6497	2 DENTAL PROPHYLAXIS ALLOWED PER YEAR FOR CLIENTS 21 AND OVER FTC RESTRICTION		3 CO	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.	1/1/2014	12/31/2299
6498	2 FLUORIDE PRESCRIPTION EACH 6 MONTHS FTC RESTRICTION		3 CO	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.	1/1/2014	12/31/2299
6499	LIMIT TO 4 EVALUATION PER CALENDAR YEAR		3 CO	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.	1/1/2014	12/31/2299
6500	ONE ROOT CANAL PER TOOTH PER LIFETIME		3 CO	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.	1/1/2014	12/31/2299
6501	TWO PER LIFETIME PER TOOTH		3 CO	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.	1/1/2014	12/31/2299
6502	HOME MODS LIMIT TO $15 000/5 YEAR PERIOD.		3 CO	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.	4/1/2015	12/31/2299
6503	TRANSITIONAL SERVICES LIMIT TO $2000/2 YEAR PERIOD.		3 CO	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.	4/1/2015	12/31/2299
6504	ASSISTIVE TECHNOLOGY LIMIT TO $5 000/ANNUALLY		3 CO	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.	4/1/2015	12/31/2299
6505	ONE PER 6 MONTHS		3 CO	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.	2/13/2015	12/31/2299
6506	LIMIT 1530Z TO ONE PER MONTH		3 CO	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.	3/20/2015	12/31/2299
6507	1 BITEWING PROC ALLOWED PER CALENDAR YR CLIENT <21		3 CO	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.	5/1/2015	12/31/2299
6508	SMOKING CESSATION GROUP COUNSELING NOT TO EXCEED 24 UNITS IN ROLLING CALENDAR Y		3 CO	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.	6/1/2015	12/31/2299
6509	SMOKING CESSATION GROUP COUNSELING NOT TO EXCEED 24 UNITS IN ROLLING CALENDAR Y		3 CO	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.	6/1/2015	12/31/2299
6510	2 DENTAL VISIT ALLOWED PER 365 DAYS		3 CO	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.	8/1/2015	12/31/2299
6511	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 12 MONTHS FOR CLIENTS 21 AND OVER		3 CO	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.	9/1/2015	12/31/2299
6512	PERIODIC ORAL EVALUATION LIMITED TO 2 PER 12 MONTHS FOR LTC RESIDENTS CLIENTS 2		3 CO	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.	9/1/2015	12/31/2299
6513	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER YEAR FOR CLIENTS 21 AND OVER		3 CO	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.	9/1/2015	12/31/2299
6514	2 DENTAL PROPHYLAXIS ALLOWED PER YEAR FOR LTC RESIDENTS 21 AND OVER		3 CO	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.	9/1/2015	12/31/2299
6515	RECORDS SHOW THAT A FLUORIDE TREATMENT HAS BEEN BILLED IN THE PAST 6 MONTHS.		3 CO	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.	9/1/2015	12/31/2299
6516	2 FLUORIDE PRESCRIPTION EACH 6 MONTHS FOR LTC RESIDENTS		3 CO	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.	9/1/2015	12/31/2299
6517	2 PER ROLLING CALENDAR YEAR		3 CO	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.	9/30/2015	12/31/2299
6518	LIMIT REIMBURSEMENT FOR A DELUXE EYEGLASS FRAME TO ONE UNIT PER CLIENT 21 AND O		3 CO	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.	11/12/2015	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6519	BILLING OF EACH CODE IS ONLY ALLOWED ONCE PER DAY		3 CO	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.	1/1/2016	12/31/2299
6520	ONE PROCEDURE CODE PER DAY		3 CO	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.	1/1/2016	12/31/2299
6521	QTY LIMIT MEDICAL SURGE SUPPLY 4 PER 6 MONTHS		3 CO	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.	3/1/2016	12/31/2299
6522	QTY LIMIT MEDICAL SURGE SUPPLY 1 PER 2 CALENDAR YEARS		3 CO	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.	3/1/2016	12/31/2299
6523	QTY LIMIT MEDICAL SURGE SUPPLY 2 PER SIX MONTHS		3 CO	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.	3/1/2016	12/31/2299
6524	TCM LIMITED TO 3HRS PER MONTH		3 CO	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.	7/1/2016	12/31/2299
6525	BEHAVORIAL HEALTH HOME - ONE PER MONTH		3 CO	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.	10/1/2015	12/31/2299
6526	1 RESTORATION PER TOOTH SURFACE ALLOWED PER 2 YR		3 CO	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.	8/1/2016	12/31/2299
6527	1 SERVICE PER CALENDAR YEAR		3 CO	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.	12/1/2016	12/31/2299
6528	6 UNITS PER CLIENT EVERY 60 DAYS		3 CO	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.	12/1/2016	12/31/2299
6529	1 DBT PROCEDURE CODE PER DAY		3 CO	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.	7/1/2016	12/31/2299
6530	PA REQUIRED FOR MORE THAN TWO OCCUPATIONAL THERAPY VISITS PER WEEK		3 CO	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.	7/1/2016	12/31/2299
6531	PA REQUIRED FOR > 1 EVAL PER CY UNDER HUSKY B		3 CO	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.	7/1/2017	12/31/2299
6532	4 UNITS OF EVALUATION ALLOWED PER CALENDAR YEAR		3 CO	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.	9/1/2017	12/31/2299
6533	8 UNITS OF EVALUATION ALLOWED PER CALENDAR YEAR		3 CO	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.	9/1/2017	12/31/2299
6534	40 UNITS OF EVALUATION ALLOWED PER CALENDAR YEAR		3 CO	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.	7/1/2017	12/31/2299
6535	QUANTITY LIMITATION 10 PER MONTH FOR MED SURGE SUPPLY		3 CO	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.	3/1/2018	12/31/2299
6536	QUANTITY LIMITED TO 1 PER 3 MONTHS		3 CO	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.	8/1/2018	12/31/2299
6537	4 UNITS OF MULTI DENSITY INSERTS ALLOWED PER 6 MONTHS		3 CO	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.	3/1/2019	12/31/2299
6538	32 UNITS OF ASSESSMENTS ALLOWED PER CALENDAR YEAR		3 CO	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.	10/1/2019	12/31/2299
6539	BLOOD PRESSURE MONITORS - LIMIT 1 PER 3 YEARS		3 CO	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.	11/1/2019	12/31/2299
6540	QTY LIMIT 3 PER CAL MONTH FOR MED SURGE SUPPLY		3 CO	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.	9/1/2020	12/31/2299
6541	TELEDENTISTRY LIMITED TO 2 TIMES PER MONTH		3 CO	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.	3/26/2020	12/31/2299
6542	LIMIT 5 VISITS PER MONTH FOR CHIROPRACTIC		3 CO	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.	10/1/2021	12/31/2299
6543	REQUIRE PA IF 20 UNITS IS EXCEEDED IN CALENDAR WK		3 CO	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.	6/1/2022	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
6545	G0512 LIMIT ONE PER MONTH		3 CO	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.	7/1/2024	12/31/2299
6546	GREATER THAN 4 DOULA PRE/POST NATAL VISITS REQ PA		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2025	12/31/2299
6554	MILLIGRAM MORPHINE EQUIVALENCY (MME) LIMIT EXCEEDED		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			8/1/2016	12/31/2299
6557	CHARTER OAK PHARMACY BENEFIT EXCEEDED.							1/1/2014	12/31/2299
6558	ONE (1) EVALUATION ALLOWED PER CALENDAR YEAR		3 CO	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.	7/1/2016	12/31/2299
6559	PA REQUIRED AFTER 3 MONTHS (6 UNIT LIMIT)		3 CO	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.	10/1/2017	12/31/2299
6560	1 SERVICE PER 14 DAYS		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2019	12/31/2299
6561	PA REQ MORE THAN 21 ECT SERVICES PER 90 DAY		3 CO	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.	1/1/2021	12/31/2299
6562	INFUSION SET WITH MODIFIER LIMITED TO $143.48 PER MONTH.		3 CO	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.	10/1/2022	12/31/2299
6564	HUSKY B PT/OT/SLP 2 VISITS PER WEEK		3 CO	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.	10/7/2022	12/31/2299
6570	LIFETIME LIMIT EXCEEDED FOR PERMANENT TOOTH		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	12/1/2022	12/31/2299
6571	ONLY 1 UNIT PER ARCH PER PERMANENT TOOTH EVERY 4 MONTHS		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	12/1/2022	12/31/2299
6572	ONLY 1 UNIT PER ARCH PER PRIMARY TOOTH EVERY 3 MONTHS		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	12/1/2022	12/31/2299
6700	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6701	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6702	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6703	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6704	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6705	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6706	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6707	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6708	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6709	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6710	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6711	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6712	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6713	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6714	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6715	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6716	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6717	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6718	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6719	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED							1/1/2014	12/31/2299
6720	BH CLINICIAN PROVIDER DAILY LIMIT OF 12 HOURS EXCEEDED		3 CO	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.	12/1/2021	12/31/2299
6850	ONLY ONE INITIAL HOSPITAL VISIT ALLOWED PER ADMISSION.		3 CO	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.	1/1/2014	12/31/2299
6851	INPATIENT RESERVE DAYS OVER 15 ARE NOT COVERED.		3 CO	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.	1/1/2014	12/31/2299
6904	LIMIT MLIA CLIENTS TO 90 DAYS LONG TERM CARE CVRG PR ADM							1/1/2014	12/31/2299
7500	OUT OF STATE PROVIDER BILLING NON-XOVR DME SERVICE OR CLAIM DENIED AFTER DSS RE		3 CO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N570	Missing/incomplete/invalid credentialing data	1/1/2014	12/31/2299
7501	DENIED MUE DETAIL AFTER REVIEW		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2018	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
7502	DENIED MUE DETAIL NEVER RECEIVED OR NEEDS ADDITIONAL INFORMATION FOR FURTHER RE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2018	12/31/2299
7508	QUANTITY DISPENSED ON RESPONSE CLAIM SAME AS ORIGINAL CLAIM.		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1/1/2014	12/31/2299
7510	RESUBMIT VIA PAPER CLAIM WITH PATHOLOGY REPORT ATTACHED		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			9/4/2014	12/31/2299
7511	RESUBMIT VIA PAPER CLAIM WITH OPERATIVE REPORT ATTACHED.		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			9/4/2014	12/31/2299
7512	RESUBMIT VIA PAPER CLAIM WITH PRE-OP X-RAY.		3 CO	197	Precertification/authorization/notification/pre-treatment absent.			9/4/2014	12/31/2299
7513	RESUBMIT VIA PAPER CLAIM WITH DESCRIPTION OF SERVICE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N34	Incorrect claim form/format for this service.	9/5/2015	12/31/2299
7514	CANNOT PRICE CLAIM DUE TO M/I INVOICE/PROOF OF PURCHASE OF DISPENSED NDC; PLEAS		1 CO	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).	M23	Missing invoice.	9/5/2015	12/31/2299
7515	MISMATCHED NDC/J-CODE OR VACCINE/TOXIN NDC/PROC CODE COMBINATION; PLEASE CORREC		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	1/1/2014	12/31/2299
7516	UNCLASSIFIED J-CODE MAY NOT BE SUBMITTED FOR NDC WITH A UNIQUE PROCEDURE CODE		2 CO	189	Not otherwise classified or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N657	This should be billed with the appropriate code for these services.	1/1/2014	12/31/2299
7517	PROFESSIONAL CLAIM SUBMITTED WITH NO NDC		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	1/1/2014	12/31/2299
7518	PROFESSIONAL CLAIM SUBMITTED WITH INVALID DOSE OR UNIT OF MEASURE		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	1/1/2014	12/31/2299
7519	THE CONSENT FORM HAS NOT YET BEEN RECEIVED		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	9/5/2015	12/31/2299
7520	THE CONSENT FORM IS INCOMPLETE		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	9/5/2015	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
7521	THE STERILIZATION WAS NOT PERFORMED WITHIN 180 DAYS OF THE CLIENTS CONSENT		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	9/5/2015	12/31/2299
7522	THE STERILIZATION WAS PERFORMED BEFORE 30 DAY WAITING PERIOD ELAPSED		3 CO	179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2014	12/31/2299
7523	DATE OF SERVICE ON CLAIM DOES NOT MATCH DATE OF SERVICE ON CONSENT FORM		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	9/5/2015	12/31/2299
7524	SIGNATURE DATE OF PERSON OBTAINING CONSENT <> CLIENTS SIGNATURE DATE		1 CO	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT)	N28	Consent form requirements not fulfilled.	9/5/2015	12/31/2299
7525	NDC IS NOT ACTIVE IN FDA DATABASE ON CLAIM DATE OF SERVICE; PLEASE CORRECT CLAI		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	3/1/2018	12/31/2299
7526	NDC HAS BEEN REPLACED WITH NEW NDC; PLEASE CORRECT CLAIM AND RESUBMIT		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	3/1/2018	12/31/2299
7527	LABELER IS NOT IN REBATE ON DOS OR CLIENT'S BENEFIT PLAN IS NOT INCLUDED IN REB		3 CO	204	This service/equipment/drug is not covered under the patient?s current benefit plan			3/1/2018	12/31/2299
7528	SUBMITTED INVOICE PROVIDES LESS UNITS THAN QUANTITY DISPENSED; PLEASE REMIT NEW		1 CO	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).			3/1/2018	12/31/2299
8135	CLAIM ADJUSTED DUE TO PATIENT LIABILITY CHANGE.							1/1/2014	12/31/2299
8182	CLAIM MASS ADJUSTED DUE TO AN APC CHANGE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/4/2014	12/31/2299
8183	CLAIM WAS ADJUSTED DUE TO RETRO CLIENT DATE OF DEATH UPDATE.		2 CO	13	The date of death precedes the date of service.			1/1/2014	12/31/2299
8184	CLAIM OR DETAIL ON CLAIM ADJUSTED DUE TO LOSS OF LICENSE / CERTIFICATION		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2016	12/31/2299
8185	CLAIM MASS ADJUSTED DUE TO A DRG CHANGE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/4/2014	12/31/2299
8186	CLAIM WAS ADJUSTED DUE TO A PROVIDER RATE CHANGE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
8187	CLAIM WAS ADJUSTED DUE TO AN MSA RATE CHANGE.							1/1/2014	12/31/2299
8188	PROVIDER RECOUPED CLAIM		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8189	CLAIM WAS ADJUSTED DUE TO A PCMH AND/OR PCP PROVIDER CHANGE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8200	CLAIM WAS ADJUSTED AS A RESULT OF A PAYMENT APPEAL		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8201	CLAIM WAS ADJUSTED AS A RESULT OF SAGA REPRICING							1/1/2014	12/31/2299
8202	CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
8203	HMS ADJUSTMENT		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
8204	PARTIAL RECOUPMENT BY A PAID CLAIM ADJUSTMENT REQUEST							1/1/2014	12/31/2299
8205	REQUESTED DATA UPDATED BY PAID CLAIM ADJUSTMENT REQUESTS		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8206	TPL - MEDICARE HOME HEALTH PROJECT FULL RECOUPMENT		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
8207	TPL - MEDICARE HOME HEALTH PROJECT PARTIAL RECOUPMENT		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
8208	CLAIM WAS ADJUSTED AS A RESULT OF A QA REVIEW		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2016	12/31/2299
8209	TPL - MEDICARE NURSING HOME PROJECT FULL RECOUPMENT		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			1/1/2024	12/31/2299
8210	TPL - MEDICARE NURSING HOME PROJECT ADJUSTMENT		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			1/1/2024	12/31/2299
8228	HMS DRG CODING REVIEW ADJUSTMENT. CONTACT HMS AT 866-206-6855.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N208	Missing/incomplete/invalid DRG code	1/1/2021	12/31/2299
8229	HMS - DRG RECOUPMENT. CONTACT HMS AT 866-206-6855.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	N208	Missing/incomplete/invalid DRG code	5/1/2021	12/31/2299
8230	HMS Medicare Part A/B Recovery		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
8231	CLAIM RECOUPMENT DUE TO VOIDED PAYMENT.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8232	CLAIM WAS ADJUSTED AS A RESULT OF A PROVIDER REFUND.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8233	CLAIM WAS ADJUSTED AS A RESULT OF A PARTIAL PROVIDER REFUND							1/1/2014	12/31/2299
8234	CLAIM WAS RECOUPED DUE TO APPLIED INCOME CHANGE. NEW CLAIM WILL BE SYSTEMATICAL		3 CO	151	Payment adjusted because the payer deems the information submitted does not support this many services.			1/1/2015	12/31/2299
8235	CLAIM ADJUSTED DUE TO A NCCI AUDIT		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			1/1/2015	12/31/2299
8236	CLAIM WAS RECOUPED DUE TO PA CHANGE. NEW CLAIM WILL BE SYSTEMATICALLY CREATED		3 CO	151	Payment adjusted because the payer deems the information submitted does not support this many services.			9/5/2015	12/31/2299
8237	CLAIM SYSTEMATICALLY REPROCESSED DUE TO RETRO CHANGE - INFORMATIONAL ONLY							1/1/2014	12/31/2299
8238	CLAIM SYSTEMATICALLY REPROCESSED DUE TO A RETRO CHANGE							1/1/2014	12/31/2299
8239	ACA CLIENT TEMP ID REPLACED WITH CMAP ID. NEW CLAIM WILL BE SYSTEMATICALLY GENE		3 CO	31	Claim denied as patient cannot be identified as our insured.			1/1/2014	12/31/2299
8240	CLAIM WAS ADJUSTED DUE TO A RETRO ME UPDATE		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
8241	CLAIM WAS HISTORY ADJUSTED DUE TO A RETRO ME UPDATE.		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
8242	CLAIM WAS ADJUSTED DUE TO A RCC RATE CHANGE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8243	CLAIM WAS ADJUSTED DUE TO A RATE CHANGE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8244	CLAIM WAS ADJUSTED DUE TO A UCC RATE CHANGE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8245	CLAIM RECOUPED AS PART OF A SYSTEMATIC RECOUPMENT.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8246	CLAIM WAS MASS ADJUSTED DUE TO A SPECIAL ALLOWED GREATER THAN BILLED MASS ADJUS		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8247	CLAIM ADJUSTED BY RETRO ME UPDATE. CLIENT NO LONGER RESPONSIBLE FOR COST SHARE		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
8248	SPECIAL CHC COST SHARE PROCESSING - INFORMATION ONLY		3 CO	151	Payment adjusted because the payer deems the information submitted does not support this many services.			9/5/2015	12/31/2299
8249	CLAIM WAS HISTORY ADJUSTED DUE TO RETROACTIVE ASSIGNMENT PLAN		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
8250	CLAIM REPROCESSED WITH EMS RECIPIENT ID. ORIGINAL CLAIM WITH AHCT TEMP ID RECOU		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
8251	CLAIM WAS HISTORY ADJUSTED FOR RETROACTIVE FEDERAL FINANCIAL REPORTING							1/1/1900	12/31/2299
8400	FIRST PERIAPICAL CANNOT BE BILLED ON SAME DAY AS BITEWINGS OR PANORAMIC		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2016	12/31/2299
8401	FEE FOR ROOT CANAL INCLUDES ALL PRE- AND POST-OPERATIVE X-RAYS		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2016	12/31/2299
8425	CLAIM WAS ADJUSTED AS A RESULT OF A QA REVIEW		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2016	12/31/2299
8513	CLIENT LOCATION RESTRICTION.		3 CO	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	M77	Missing/incomplete/invalid/inappropriate place of serivce.	1/1/2014	12/31/2299
8515	THIS CLAIM HAS BEEN DENIED DUE TO A REVERSAL TRANSACTION.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
8599	REIMBURSED WITH COVID 19 PRICING		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			3/1/2020	12/31/2299
8600	REIMBURSED VIA DRG PRICING		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8601	CLAIM CONTAINED HCAC - PRICED AT LOWER RATE		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8602	CLAIM CONTAINED HCAC -NO IMPACT TO PRICING		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8602	CLAIM CONTAINED HCAC -NO IMPACT TO PRICING							1/1/2014	12/31/2299
8603	DRG OUTLIER AMOUNT APPLIED		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
8604	REIMBURSED WITH DRG TRANSFER RATE		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8605	REIMBURSED WITH PRORATED ELIGIBILITY ADJUSTMENT		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8606	REIMBURSED VIA GENERAL BH PRICING		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8607	REIMBURSED VIA REHAB PRICING		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8608	REIMBURSED AT DRG RATE - REHAB RATE NOT AVAILABLE		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8609	REIMBURSED AT DRG RATE - GENERAL BH RATE NOT AVAILABLE		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8610	INPATIENT STAY SPANS MULTIPLE BENEFIT PLANS		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8611	1ST ACCOMMODATION DETAIL IS PAID		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
8620	APC PACKAGED SERVICE	4	CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			7/1/2016	12/31/2299
8621	APC PRICING APPLIED	3	CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	7/1/2016	12/31/2299
8622	APC OUTLIER PAYMENT APPLIED	3	CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	7/1/2016	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
8700	LAB PROCEDURE NOT COVERED FOR OUTPATIENT CROSSOVER		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: 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.	1/1/2014	12/31/2299
9000	THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9001	REIMBURSEMENT REDUCED BY THE CLIENT'S CO-PAYMENT AMOUNT.		PR	3	Co-payment Amount			1/1/2014	12/31/2299
9002	REFUND CO-PAY FROM ORIGINAL CLAIM TO CLIENT. CLIENT NO LONGER RESPONSIBLE FO		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
9003	PAID AMOUNT REDUCED TO ZERO		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9004	CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.			1/1/2016	12/31/2299
9005	CLIENT RETROACTIVELY MEDICAID ELIGIBLE- REVERSE THEN REBILL PDP- BILL CO-PAY T		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
9008	CLIENT NO LONGER RESPONSIBLE FOR COINSURANCE/DEDUCTIBLE/CO-PAY. REFUND ANY O		3 CO	150	Payment adjusted because the payer deems the information submitted does not support this level of service.			9/5/2015	12/31/2299
9009	REIMBURSEMENT REDUCED BY PARTIAL CO-PAYMENT AMOUNT.		PR	3	Co-payment Amount			1/1/2014	12/31/2299
9010	CLIENT EXEMPT FROM COPAY							1/1/2014	12/31/2299
9011	OUT-OF-POCKET MAXIMUM COPAY MET							1/1/2014	12/31/2299
9100	PAID MANUALLY PRICED CLAIM		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9101	DENIED MANUALLY PRICED CLAIM AFTER REVIEW		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9102	SUSPENDED MANUALLY PRICED CLAIM REQUIRES MEDICAL SUMMARY FOR FURTHER REVIEW - F		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9907	TPL AMOUNT APPLIED.		3 CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9/5/2015	12/31/2299
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			9/5/2015	12/31/2299
9910	PHARMACY DISPENSING FEE APPLIED.							1/1/2014	12/31/2299
9914	PRICING ADJUSTMENT - RCC FLAT FEE PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	5/1/2016	12/31/2299
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED.		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2014	12/31/2299
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2014	12/31/2299
9919	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9922	PATIENT LIABILITY APPLIED INCOME OR SPENDDOWN AMOUNT APPLIED.		PR	142	Claim adjusted by the monthly Medicaid patient liability amount.			1/1/2014	12/31/2299
9923	PAYMENT AMOUNT REDUCED BY CLIENT CONTRIBUTION		PR	2	Coinsurance Amount			1/1/2014	12/31/2299
9926	CLAIM HAS CUTBACK AMOUNT.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9928	PRICING ADJUSTMENT - ANESTHESIA PRICING APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9929	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED USING MULTIPLE RATES.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9930	PRICING ADJUSTMENT - LONG TERM CARE NON COVERED DAYS.		3 CO	B1	Non-covered visits.	N30	Patient ineligible for this service.	1/1/2014	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
9931	PRICING ADJUSTMENT - LONG TERM CARE SERVICE NOT PAYABLE.		2 CO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Re	M51	Missing/incomplete/invalid procedure code(s).	1/1/2014	12/31/2299
9934	PRICING ADJUSTEMENT - PAY UP TO MAX FEE PRICING APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9935	PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9939	PRICING ADJUSTMENT - LESSER OF BILLING OR PERFORMING PROVIDER UCC.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9940	PROFESSIONAL DRUG FEE PRICING WAS APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	7/1/2016	12/31/2299
9941	NDCLOW AMOUNT PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	7/1/2016	12/31/2299
9950	SERVICE IS COVERED BY MONTHLY MATERNITY BUNDLE CASE RATE PAYMENT.		CO	245	Provider performance program withhold.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	4/1/2024	12/31/2299
9960	PRICING ADJUSTMENT - PSYCHIATRIC HOSPITAL 30 PLUS DAY RATE APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9961	PRICING ADJUSTMENT - ORGAN ACQUISITION COST		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			1/1/2015	12/31/2299
9963	PRICING ADJUSTMENT - PHYSICIAN ASSISTANT PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9964	PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9965	ACA ENHANCED RATE ADD ON		CO	260	Additional payment for Dental/Vision service utilization.			1/26/2014	12/31/2299
9967	MSA LOW RATE APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2016	12/31/2299
9968	FQHC PCMH ADJUSTMENT TO COMPLY WITH SPA CT 12-005							1/1/1900	12/31/2299
9969	PCMH HEALTH CENTER							1/1/2014	12/31/2299
9970	PRICING ADJUSTMENT - FULL LCA RATE APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9971	PRICING ADJUSTMENT - PARTIAL OR NO LCA RATE APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9972	PRICING ADJUSTMENT - PCMH PARTIAL OR NO PERCENT RATE APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9973	PRICING ADJUSTMENT - PCMH PARTIAL OR NO FIXED AMT APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9974	PRICING ADJUSTMENT - PCMH FIXED AMOUNT APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9975	PRICING ADJUSTMENT - PCMH PERCENTAGE RATE APPLIED		CO	144	Incentive adjustment e.g. preferred product/service.			1/2/2014	12/31/2299
9976	PRICING ADJUSTMENT - METROPOLITAN STATISTICAL AREA PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9977	PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9978	PRICING ADJUSTMENT - DEFICIT REDUCTION ACT (DEFRA) PRICING APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9979	PRICING ADJUSTMENT - OUTPATIENT HOSPITAL LAB FEE PRICING APPLIED.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9980	ANCILLARY SERVICES INCLUDED IN PER DIEM RATE OR DRG RATE.		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: 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.	1/1/2014	12/31/2299
9981	REDUCED TO MAXIMUM ALLOWABLE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.			1/1/2016	12/31/2299

Non-Pharmacy EOB X-Ref

Run Date: 4/25/2025

EOB	EOB Description	Business Scenario	CAGC	CARC	CARC Description	RARC	RARC Description	Eff Date	End Date
9982	INPATIENT PROF FEES ARE EXCLUDED FROM DRG PRICING AND ARE REIMBURSED SEPARATELY		4 CO	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: 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.	1/1/2015	12/31/2299
9983	PAYMENT AMOUNT REFLECTS DENTAL ARCH/TOOTH PRICING		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	11/1/2022	12/31/2299
9990	PRICED AFTER MANUAL REVIEW.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9991	BILLED UNITS HAVE BEEN CUTBACK TO CONTRACT MAXIMUM		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9992	PAYMENT AMOUNT REFLECTS TOOTH SURFACE PRICING		CO	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s)			7/1/2015	12/31/2299
9993	FQHC BILLING NON-FQHC SERVICE OR PCMH PRIMARY CARE CLINIC - PRICED USING RENDER							1/1/2014	12/31/2299
9994	PAYMENT AMOUNT REFLECTS FIXED FEE ALLOWED PER RCC PER DATE OF SERVICE		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
9996	REFER TO HEADER EOB		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N35	Program integrity/utilization review decision.	1/1/2014	12/31/2299
9997	REFER TO DETAIL EOB		3 CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	N35	Program integrity/utilization review decision.	1/1/2014	12/31/2299
9998	REDUCED TO MAXIMUM ALLOWABLE.		3 CO	119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	1/1/2014	12/31/2299
	Total # of EOBs		1443						

Business Scenario Descriptions
1. Additional Information Required. Documentation Missing/Invalid/Incomplete
2. Additional Information Required. Data from Submitted Claim Missing/Invalid/Incomplete
3. Billed Service not Covered by Health Plan
4. Benefit for Service is not Separately Payable

Claim Adjustment Code Groups
CO-Contractual Obligations
PI-Payer Initiated Reducations
PR-Patient Responsibility
OA-Other Adjustments

Note: The EOB can be found on the RA PDF.
The CARC/RARC can be found on the 835.