CARC	CARC Description	RARC	RARC Description	Explanation Code
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.			5A9
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.	M20	Missing/incomplete/invalid HCPCS.	04C
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.	M51	Missing/incomplete/invalid procedure code(s).	04A
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.	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. Visit CMS.gov and search for Medicare Coverage Database to find a copy of the policy.	04B
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.	5C3
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.	ZK2
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 service.	I68
6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.	V78

CARC	CARC Description	RARC	RARC Description	Explanation Code
7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			07A
9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.	ZH3
10	The diagnosis is inconsistent with the patients gender. 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.	ISR
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.	M76	Missing/incomplete/invalid diagnosis or condition.	11R
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.	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. Visit CMS.gov and search for Medicare Coverage Database to find a copy of the policy.	11N
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance			16R
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	IIJ

CARC	CARC Description	RARC	RARC Description	Explanation Code
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	N846	National Drug Code (NDC) supplied does not correspond to the HCPCs/CPT billed.	IIN
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	18R
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.	5CM
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	N356	Not covered when performed with, or subsequent to, a non-covered service.	96C
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	N425	Statutorily excluded service(s).	96B
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	N428	Not covered when performed in this place of service.	96D
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	N808	Not covered for this provider type / provider specialty.	96A

CARC	CARC Description	RARC	RARC Description	Explanation Code
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.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	97E
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.	97A
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.	97C
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.	N390	This service/report cannot be billed separately.	97D
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.	N525	These services are not covered when performed within the global period of another service.	97B
108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			1A8
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.	19A

CARC	CARC Description	RARC	RARC Description	Explanation Code
119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	19C
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.	R46
119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	19D
119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	19B
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N640	Exceeds number/frequency approved/allowed within time period.	51A
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.			5BJ
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.	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, yo	1RA
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.	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. Visit CMS.gov and search for Medicare Coverage Database to find a copy of the policy.	1RB
181	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.	81A
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 specialty.	85A
211	National Drug Codes (NDC) not eligible for rebate, are not covered.			11B

CARC	CARC Description	RARC	RARC Description	Explanation Code
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			32B
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	34D
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.)	N20	Service not payable with other service rendered on the same date.	34B
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.)	N390	This service/report cannot be billed separately.	34C
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.)	N640	Exceeds number/frequency approved/allowed within time period.	34E
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 schedul			36B
272	Coverage/program guidelines were not met.			72B
273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	73A
273	Coverage/program guidelines were exceeded.	N640	Exceeds number/frequency approved/allowed within time period.	73B

CARC	CARC Description	RARC	RARC Description	Explanation Code
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.) Usage: Use this code only when a more specific Claim Adjustment Reason Code	N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	A1A
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.	R39
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 Paym	M51	Missing/incomplete/invalid procedure code(s).	1B5