Remittance Advice Remark Codes Related to the No Surprises Act

Remittance Advice Remark Codes (RARCs) may be used by plans and issuers to communicate information about claims to providers and facilities, subject to state law.

The following RARCs related to the No Surprises Act have been approved by the RARC Committee and are effective as of March 1, 2022.

For a complete and regularly updated list of RARCs, please see https://x12.org/codes/remittance-advice-remark-codes.

The No Surprises Act Provisions that Apply to the Claim	
RARC #	RARC Text
N864	Alert: This claim is subject to the No Surprises Act provisions that apply to emergency services.
N865	Alert: This claim is subject to the No Surprises Act provisions that apply to nonemergency services furnished by nonparticipating providers during a patient visit to a participating facility.
N866	Alert: This claim is subject to the No Surprises Act provisions that apply to services furnished by nonparticipating providers of air ambulance services.

How Cost Sharing Was Calculated under the No Surprises Act	
RARC #	RARC Text
N862	Alert: Member cost share is in compliance with the No Surprises Act, and is calculated using the lesser of the QPA or billed charge.
N867	Alert: Cost sharing was calculated based on a specified state law, in accordance with the No Surprises Act.
N868	Alert: Cost sharing was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.
N869	Alert: Cost sharing was calculated based on the qualifying payment amount, in accordance with the No Surprises Act.
N870	Alert: In accordance with the No Surprises Act, cost sharing was based on the billed amount because the billed amount was lower than the qualifying payment amount.

Initial Payment Amount	
RARC #	RARC Text
N871	Alert: This initial payment was calculated based on a specified state law, in accordance with the No Surprises Act.
N877	Alert: This initial payment is provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate.

Final Payment Amount	
RARC #	RARC Text
N863	Alert: This claim is subject to the No Surprises Act (NSA). The amount paid is the final out-of-network rate and was calculated based on an All Payer Model Agreement, in accordance with the NSA.
N872	Alert: This final payment was calculated based on a specified state law, in accordance with the No Surprises Act.
N873	Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.
N874	Alert: This final payment was determined through open negotiation, in accordance with the No Surprises Act.
N875	Alert: This final payment equals the amount selected as the out-of-network rate by a Federal Independent Dispute Resolution Entity, in accordance with the No Surprises Act.

Denial of Payment	
RARC #	RARC Text
N876	Alert: This item or service is covered under the plan. This is a notice of denial of payment provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate than the amount paid by the patient in cost sharing.

Notice and Consent	
RARC #	RARC Text
N878	Alert: The provider or facility specified that notice was provided and consent to balance bill obtained, but notice and consent was not provided and obtained in a manner consistent with applicable Federal law. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.
N879	Alert: The notice and consent to balance bill, and to be charged out-of-network cost sharing, that was obtained from the patient with regard to the billed services, is not permitted for these services. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.

Miscellaneous	
RARC #	RARC Text
N830	Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es).
N859	Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).

For more on health care payment and remittance advice, please see https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/HealthCarePaymentandRemittanceAdviceandElectronicFundsTransfer or https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.