

Non-covered service; plan benefit documents must be obtained to identify exclusion basis

Provider billing perspective · confidence medium · No external reference grounding · anthropic claude-sonnet-4-5-20250929 · 9/27/2026, 6:08:27 PM

At most medium here: no approved reference was retrieved.

CASE IDENTITY · LOCAL ONLY, NOT SENT TO THE AI

Patient	GRACE OKAFOR
Claim	CLM0003256
Service date	20260614
Internal case	8162

APPLICATION-CALCULATED FACTS

Denial reason	CARC 96 · RARC N130
Root cause	NON_COVERED
Payer	CASCADE CARE
Billed	\$676.00
Payer paid	\$0.00
Provider impact	\$0.00
Patient responsibility	\$439.40
Appeal window	OPEN · 359 days

- Payer reported CARC 96 with RARC N130.
- The service date falls within the enrolment span on file (834).
- No eligibility response (271) is on file, so eligibility on the service date was not verified.
- Policy-reference presence was not captured for this previously ingested 835; absence from the AI case cannot be treated as payer omission.

OFFICIAL CODE WORDING

- CARC 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. [reference published 2025-11-01]
- RARC N130: Consult plan benefit documents/guidelines for information about restrictions for this service. [reference published 2026-09-21]

Factual summary

- CASCADE CARE denied the \$676.00 charge with CARC 96 (non-covered) and RARC N130 (consult plan benefit documents for service restrictions).
- Service date falls within the enrollment span on file; no eligibility verification (271) is on file for that date.
- Payer paid \$0.00; contractual adjustment of \$236.60 applied; patient responsibility reported as \$439.40.
- CARC 96 directs review of 835 loop 2110 REF policy identifiers if present; policy-reference presence was not assessed for this remittance.

Interpretation

The payer classified this office visit (99213) for diabetes mellitus (E119) as non-covered and directed the provider to plan benefit documents. The CO adjustment suggests a contractual write-off, while the PR balance indicates patient liability. The specific coverage exclusion is unknown and must be determined from the plan's benefit schedule. The \$439.40 patient responsibility may reflect cost-sharing or balance transfer rules that require contract verification.

Recommended investigation

1. Obtain CASCADE CARE plan benefit documents and coverage schedule applicable to the service date.
RARC N130 explicitly directs to plan documents; the specific non-covered criterion is not stated in case facts or codes.
2. Review the original 835 remittance for loop 2110 REF segments (policy reference qualifiers and numbers).
CARC 96 usage instructions state to refer to this segment if present; policy_reference_status is not_assessed, so its presence is unknown.
3. Verify provider participation status and fee schedule with CASCADE CARE for the service date.
A \$236.60 contractual adjustment is reported; confirming network status and contract terms is necessary to validate the CO adjustment and patient liability calculation.
4. Confirm patient enrollment and benefit effective dates via a service-date eligibility verification.
Service is within the 834 enrollment span, but no eligibility response (271) is on file; contemporaneous verification evidence is needed.

Possible appeal path

If plan documents show the service should be covered, submit a reconsideration request with the benefit schedule provision and enrollment verification. If the exclusion is valid but the PR liability calculation is disputed, request contract terms and fee schedule documentation. The appeal window remains open with 359 days remaining; confirm the payer's reconsideration versus appeal process and any required forms.

Evidence to gather

- CASCADE CARE benefit schedule and coverage guidelines effective on the service date.
- Original 835 remittance showing all REF segments in loop 2110 (policy reference identifiers).
- Provider participation agreement and fee schedule with CASCADE CARE covering the service date.

- Eligibility verification response (271) or enrollment verification log for the service date.

Unresolved questions

- What specific plan-defined coverage criterion caused the non-covered determination?
- Did the payer supply policy reference numbers (REF qualifiers) in the 835 loop 2110, and if so, what do they identify?
- What contract provision or state regulation governs the transfer of \$439.40 to patient responsibility after the CO adjustment?
- Was the patient's enrollment and benefit configuration verified on the service date?

Risks and limitations

- Payer-specific or regulatory guidance was not retrieved; limit conclusions to deterministic case facts and state what policy must be verified.
- Policy-reference presence in the 835 was not assessed; absence from the case cannot be treated as payer omission.
- No eligibility verification (271) is on file; enrollment span evidence (834) does not confirm active benefits on the service date.
- Provider network status and contract terms are unknown; the CO adjustment and patient liability cannot be validated without them.

Sources

No approved reference was retrieved for this denial. The analysis is limited to the application's case facts.

AI interpretation of facts calculated by the application. The facts are authoritative; the interpretation is not. Confidence begins with the model's rating and may be capped by the application when supporting evidence is missing. Verify against payer policy before acting, and handle this document as containing patient information.