# Provider Bulletin

## Central Health Medicare Plan

October 28, 2026

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## CMS RARC code reporting requirement

This is an advisory notification to Central Health Medicare Plan (CHP) network providers applicable to CHP Medicare business.

### What you need to know:

CMS has issued an update to the Medicare Advantage encounter data submission requirements related to the reporting of payment status using new informational Remittance Advice Remark Codes (RARCs). Please review the attached CMS memo, which provides the details and requirements for these new RARC codes.

**Effective September 11, 2026, CMS will begin accepting the following RARC codes:**

- N923 – Not Denied
- N924 – Pending (Not Denied)
- N925 – Denied
- N926 – Partially Denied

CMS expects MAOs to make every effort to report the appropriate RARC code reflecting the final payment status of each applicable encounter. The RARCs must be reported in the appropriate CAS segments within the 837 file. Please refer to the attached CMS memo for the specific reporting requirements and applicable 2320/2430 CAS segment locations.

### When this is happening:

Effective September 11, 2026.

## Provider action

As CHP partners with Medicare line of business, please review and adopt these requirements in your 837 encounter file submissions to support the CMS requirements.

Please confirm receipt of this communication and the attached CMS memo and provide confirmation that your 837 file generation process will be updated to meet these requirements.

Thank you for your partnership and support in ensuring our Medicare encounter submissions remain compliant with CMS requirements.

### What if you need assistance?

If you have any questions regarding this notification, please contact Provider Relations at CAProviderRelations@MolinaHealthcare.com.

Central Health Plan: 200 Oceangate, Suite 100 Long Beach, CA 90802

CENTRAL HEALTH MEDICARE PLAN

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**MEDICARE PLAN PAYMENT GROUP**

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**DATE:** July 17, 2026

**TO:** All Medicare Advantage, Cost, PACE, and Demonstration Organizations Systems Staff

**FROM:** Shruti Rajan, Acting Director, Medicare Plan Payment Group

**SUBJECT:** Encounter Data Submission Updates July 2026

The purpose of this memorandum is to provide information concerning updates to the encounter data submission requirements. Changes described below include creation of new edits, and details regarding their implementation.

The Centers for Medicare & Medicaid Services (CMS) is committed to enhancing the quality and completeness of the encounter data collected from Medicare Advantage Organizations (MA organizations). The agency believes that the encounters collected from MA organizations are largely complete and that there are opportunities to further refine the data to allow CMS to consistently identify when an MA organization determined it did not have payment responsibility for a service reported in encounter data. CMS has heard from stakeholders including the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) that the ability to identify encounters that were not ultimately the responsibility of MA organizations, where payment was denied either partially or fully, would enhance program oversight and help combat fraud, waste and abuse.[1]

In response to this feedback, CMS has established four new informational remittance advice remark codes, or RARCs, for MA organizations to provide information on an encounter's payment status as part of the encounter data submissions. The creation of informational RARCs will enable CMS to consistently identify, monitor, and analyze MA organizations' denial patterns and support program integrity oversight.

Beginning September 11, 2026, the Medicare Advantage Encounter Data System (EDS) will begin accepting the four new RARC codes; CMS strongly encourages MA organizations to use the codes ('N923', 'N924', 'N925', and 'N926')[2] to report payment status on all encounter data submissions from September 11, 2026, onward. Submitters should report the final payment status of an encounter. If the

[1] https://oig.hhs.gov/reports/all/2023/the-inability-to-identify-denied-claims-in-medicare-advantage-hinders-fraud-oversight/
[2] https://x12.org/codes/remittance-advice-remark-codes

payment status of an encounter changes after submission of an initial encounter data record (for example, from “pending” to “denied” or “not denied”), the MA organization should submit a replacement encounter reflecting the updated payment status. CMS expects MAOs will make every effort to submit the appropriate RARC code reflecting each encounter's payment status for all submissions beginning September 11, 2026. CMS will actively monitor RARC code usage and strongly encourage MAOs to seek technical assistance, as needed, to ensure accurate submission of an encounter’s payment status.

**Description of New Informational RARC Codes for Reporting Encounter Payment Status**

The table below presents definitions of the four new RARC codes and the corresponding payment status indicated by each code. CMS considers a service denied when the MA organization determines that it has no payment responsibility for the service at the time of adjudication (or re-adjudication), including circumstances where the entirety of the payment responsibility rests with another payer. As noted in the table, RARC 'N923' indicates that the MA organization has completed a payment responsibility determination, the MA organization has paid for the service, and therefore, the service was not denied at the time the encounter was submitted. RARC ‘N925’ should be used when the entire encounter was denied for payment (i.e., all service lines) or at the line level when a specific service line is denied. RARC 'N926' is reported only at the header level and indicates that one or more service lines were denied and at least one service line was not denied. In such cases, the encounter must be reported with 'N926' at the header level, and each associated service line must be reported with RARC 'N923', 'N924', or 'N925', as applicable. RARC ‘N924’ is reported only when the MA organization has not made a payment determination at the time the encounter is submitted. CMS expects that if ‘N924’ is submitted, subsequent submissions for those services will include or update ‘N924’ to 'N923', 'N925' or 'N926'.

***Table 1: Informational RARC Codes for reporting encounter payment status***

| RARC Code | Code Definition | Reporting Level |
|---|---|---|
| N923 | Not Denied - The Medicare Advantage Organization (MAO) made a payment responsibility determination. | 2320 or 2430 |
| N924 | Pending (Not Denied) - The Medicare Advantage Organization (MAO) has not yet made a payment responsibility determination for the service at the time the encounter record was submitted. | 2320 or 2430 |
| N925 | Denied - The Medicare Advantage Organization (MAO) determined that it had no payment responsibility for the service at the time the encounter record was submitted. | 2320 or 2430 |
| N926 | Partially Denied - The Medicare Advantage Organization (MAO) determined that it had no payment responsibility for one or more service lines, but not all, at the time the encounter record was submitted. | 2320 only |

**Submission of Submission of Informational RARC Codes**

The informational RARC codes should be reported in the CAS segment locations described below and will serve as the authoritative indicator of encounter payment status. Because these new RARC codes are informational, they may be submitted with or without an existing claim adjustment reason code (CARC) as reported in the Claims Adjustment Segment (CAS).

All other CARCs, RARCs, and transaction elements should continue to be reported in accordance with applicable X12 standards and CMS encounter data submission guidance.

For all applicable header and service lines, the informational RARC codes should be submitted in the 2320 or 2430 CAS segments. CMS will validate all CAS segments for presence of 'N923', 'N924', 'N925', and 'N926' on the encounter data submission. MA organizations may continue to submit CARC codes as they do today. With the exception of the instructions related to RARC codes provided in this memo, all other X12 standards pertaining to the CAS segment continue to apply and MA organizations should continue to use these X12 standards when submitting data in the CAS segment.

As previously stated, CMS will monitor the use of the aforementioned RARC codes in addition to the below informational edits that will be returned on the MAO-002 report and strongly encourages the use of the RARC codes to reflect an encounter's payment status.

**New Edits for Submission of Informational RARC Codes**

**Edit 28000 'Missing/Invalid Remittance Advice Code'** is a new header level informational edit applicable for institutional, professional, DME, and dental encounters. This informational edit validates that the encounter must contain Remittance Advice Remark Codes (RARC) ' N923', 'N924', 'N925', or 'N926' in 2320 CAS Segments. This edit will be bypassed for chart review records (CRRs).

- RARC Code 'N923', 'N924', 'N925', or 'N926' is not submitted on header in any 2320 CAS segment

**Edit 28005 'Missing/Invalid RARC on Service Line'** is a new line level informational edit applicable for institutional, professional, DME, and dental encounters. This edit validates that the encounter service lines contain Remittance Advice Remark Codes (RARC) 'N923', 'N924', 'N925' in 2430 CAS Segments for each service line when the encounter is submitted with RARC code 'N926' at header in 2320 CAS Segments. This edit will be bypassed for CRRs.

- RARC Code 'N926' (Partially Denied) is submitted on header in any 2320 CAS segment
- RARC Code 'N923', 'N924', or 'N925' is not submitted on the service line in any 2430 CAS segment

Questions can be submitted to RiskAdjustmentOperations@cms.hhs.gov. Please specify "Encounter Data Software Release payment denial informational RARCs" in the subject line. Thank you.

**Appendix A**

The Memo contains patient discharge status codes, revenue, and condition codes. The American Hospital Association (AHA) has granted to the Centers for Medicare & Medicaid Services (CMS or the agency) and its authorized agents a limited, royalty-free permission to reproduce portions of the National Uniform Billing Code (NUBC) UB-04 Data Specifications Manual and a limited license to use NUBC UB-04 Specifications Data in CMS publications, both print and electronic media, as agency requirements demand.

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