MediBillMD

List of Denial Codes in Medical Billing

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Denial Codes	Description	Common Solutions
CARC 1	It is related to the deductible amount. It means the payer will not cover the cost of the claim until the patient has paid the required deductible out of pocket.	1. Verify the patient's insurance coverage to see if they have an active deductible. 2. Ensure patients understand their financial responsibility. 3. Collect the patient's deductible upfront at the time of service.
CARC 2	It is related to the coinsurance amount. It is the portion of the medical bill that the patient is responsible for paying out of pocket after the insurance company has paid their portion.	1. Verify the patient's insurance coverage to see if they have an active deductible. 2. Ensure patients understand their coinsurance obligations. 3. Collect coinsurance upfront at the time of service.
CARC 3	It is related to the co-payment amount. It is triggered when the patient's co-payment, which is the fixed amount they are responsible for paying out-of-pocket for a specific healthcare service, has not been correctly calculated or included in the claim.	1. Verify the patient's insurance coverage to check if they have an active deductible. 2. Ensure patients understand their co-payment responsibilities. 3. Collect co-payment upfront at the time of service.
CARC 4	It is related to inconsistent modifiers. That is, the modifier attached to the procedure code does not match the requirements or guidelines set by the payer.	1. Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if it is present in the claim. 2. Ensure that the procedure code accurately matches with the appropriate modifier.
CARC 5	It is related to the inconsistent place of service (PoS). That is, the code or bill does not match the location where the service was performed.	1. Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) in the ERA if it is available. 2. Double-check the place of service code to confirm that it matches the actual location where the service was rendered.
CARC 6	It is related to the inconsistent patient age with procedural and revenue codes. This code is used to indicate that the procedure or service provided is not typically performed or covered	1. Ensure that the patient's age is accurately recorded in the system. 2. Review the patient's medical records to ensure the procedure or revenue code aligns with the documented age.

	for patients of that particular age group.	3. Enhance communication between the billing and clinical teams to prevent age-related discrepancies. 4. Conduct regular audits to identify any potential age-related coding errors.
CARC 7	It is related to the inconsistent gender with procedural or revenue code. It means that the code used to describe the service or treatment does not match the gender of the patient receiving it.	1. Ensure accurate patient demographic information during registration or intake processes. 2. Train staff on accurately documenting and coding the patient's gender. 3. Implement gender-neutral coding options. 4. Regularly review coding guidelines to stay updated on any changes or updates related to gender-specific codes.
CARC 8	It is related to inconsistent designated provider type or specialty (taxonomy). That is, the billed procedure is not typically associated with the type of services that the provider is authorized to perform.	1. Ensure accurate provider type/specialty information for each procedure. 2. Conduct regular audits to review the consistency between the procedure codes and the provider type/specialty. 3. Train your staff on provider type/specialty requirements.
CARC 10	It occurs when the diagnosis does not align with the patient's identified gender.	1. Collect and verify accurate patient information, including their gender. 2. Double-check that the patient's gender is correctly recorded in the EHR and billing systems. 3. Improve communication with healthcare providers to ensure that they are aware of the patient's correct gender.
CARC 11	It occurs when the provided diagnosis does not support the performed procedure.	1. Ensure that the diagnosis provided is consistent with the procedure performed. 2. Train staff to keep them updated with the latest coding guidelines and documentation requirements. 3. Establish effective communication channels between the coding and clinical teams.
CARC 12	It is triggered when the diagnosis provided by the healthcare provider does not match the type of provider	1. Ensure that the documented diagnosis in the medical record aligns with the rendered services by their specific provider type.

	submitting the claim.	2. Keep your staff updated with the latest coding guidelines and documentation requirements. 3. Conduct audits to review any inconsistencies or errors in the coding process.
CARC 13	It occurs when the patient's date of death comes before the date of service.	1. Regularly update patient records and cross-reference them with reliable sources such as the Social Security Death Index. 2. Employ a robust scheduling system to flag any appointments scheduled after the patient's date of death, alerting staff to potential errors. 3. Perform insurance eligibility verification, including services that are not covered due to the patient's deceased status.
CARC 14	It occurs when the patient's date of birth comes after the date of service.	1. Double-check patient information, including the patient's date of birth. 2. Implement automated checks to flag any discrepancies between the patient's date of birth and the date of service.
CARC 16	This denial code occurs when the claim is missing necessary information or contains errors related to billing.	1. Double-check claim information to identify and rectify any errors or missing information. 2. Implement claim scrubbing software to automatically detect and flag potential errors or missing information in the claim. 3. Utilize electronic claim submission for faster claim submission and reduce errors.
CARC 18	This denial code is for an exact duplicate claim or service. It is used with Group Code OA. However, in state Workers' Compensation regulations, it may be used with Group Code CO.	1. Review the claim for any duplicate services or claims. 2. Ensure accurate and detailed documentation. 3. Implement a robust claims management system with built-in checks and balances to identify potential duplicate claims.
CARC 19	It means that the claim is denied because the injury or illness is considered work-related and should be covered by a Workers' Compensation carrier.	1. Ensure accurate documentation of work-related injury or illness in the patient's medical record. 2. Submit the claim to the Workers' Compensation carrier within the deadline and comply with the

		specific requirements and guidelines. 3. Verify the patient's Workers' Compensation coverage before rendering care services.
CARC 20	It is triggered when injury or illness is covered by a liability carrier.	1. Ensure that the patient's liability carrier information is accurate and updated. 2. Obtain pre-authorization from the liability carrier. 3. Provide accurate and adequate documentation to justify medical necessity.
CARC 21	It occurs when the injury or illness being claimed is the responsibility of a no-fault carrier.	1. Make sure patient records are complete, including detailed information about the injury or illness. 2. Submit claims to the no-fault carrier within the deadline to avoid any potential delays or denials. 3. Ensure clear communication with the no-fault carrier.
CARC 22	It happens when the healthcare service may be covered by another insurance provider due to the coordination of benefits.	1. Verify the patient's insurance coverage to ensure the patient has primary insurance coverage. 2. Collect accurate patient information, including primary insurance details. 3. Submit the claim within the deadline to avoid exhausting the patient's primary insurance coverage.
CARC 23	It is used when a prior payer's decision affects the payment or adjustments made.	1. Verify the patient's eligibility and benefits with the primary payer. 2. Regularly monitor and follow up on outstanding or unpaid claims. 3. Provide complete and accurate documentation to support rendered care services.
CARC 24	It is triggered when charges are covered under a capitation agreement/managed care plan.	1. Verify eligibility to ensure the patient is enrolled in a capitation agreement or managed care plan. 2. Obtain prior authorization by submitting the required documentation to the insurance payer. 3. Ensure accurate coding that complies with the requirements and guidelines of the capitation

		agreement or managed care plan.
CARC 26	It occurs when expenses are incurred before insurance coverage starts.	1. Verify insurance eligibility to prevent expenses incurred before coverage. 2. Obtain prior authorization from the insurance company to prevent expenses incurred before coverage. 3. Ensure accurate documentation demonstrating expenses were incurred after the patient's coverage became effective.
CARC 27	You may end up with this denial code when expenses are incurred after coverage has ended.	1. Ensure timely verification of coverage before the encounter. 2. Effectively communicate with the patient and track their insurance coverage. 3. Streamline the claims submission process with thorough checks for accurate and up-to-date insurance information.
CARC 29	It indicates that the healthcare provider missed the deadline for submitting the claim.	1. Ensure timely claim submission within the specified time frame set by the payer. 2. Employ a robust system to track and monitor claim submission deadlines. 3. Use the electronic claim submission process to minimize delays and errors.
CARC 31	This denial code is triggered when the patient cannot be recognized as insured by the insurance company.	1. Ensure up-to-date insurance information is collected from patients during the registration process. 2. Implement data validation checks and double-check the accuracy to avoid data entry errors. 3. Establish effective communication with the payer to quickly resolve patient identification issues.
CARC 32	It indicates that the patient is not eligible as a dependent according to insurance company records.	1. Verify the patient's eligibility as a dependent. 2. Maintain up-to-date patient information, including their relationship to the primary policyholder. 3. Establish effective communication with the patient to ensure they report promptly.
CARC 33	This denial code occurs when the insured person does not have	1. Verify dependent coverage before claim submission.

	coverage for dependents.	2. Educate patients on coverage limitations. 3. Collect accurate patient information during the registration process, including their relationship with the insured individual.
CARC 34	This denial code indicates that the insured patient has no coverage for newborns.	1. Verify insurance coverage before rendering care services to newborns. 2. Communicate insurance policies to the insured, specifically regarding coverage for newborns. 3. Obtain necessary authorizations for newborn coverage.
CARC 35	It indicates that the lifetime benefit maximum has been reached.	1. Verify insurance coverage to determine if they have reached their lifetime benefit maximum. 2. Inform the patients about their coverage limitations, especially if their lifetime benefit maximum has been reached. 3. Prioritize essential services over non-essential ones if their lifetime benefit maximum has been reached.
CARC 39	This denial code indicates that the healthcare provider did not obtain the necessary approval or verification from the insurance company before providing the services.	1. Obtain timely authorization or pre-certification before providing care services. 2. Establish effective communication with insurance payers to understand authorization requirements. 3. Educate staff on authorization requirements.
CARC 40	It means charges do not qualify as emergent/urgent care.	1. Ensure accurate documentation for patient symptoms, situation urgency, and other relevant information to support the need for emergent or urgent care. 2. Train your staff on the specific emergent/urgent care coding guidelines. 3. Implement a pre-authorization process for emergent or urgent care services.
CARC 44	It is related to prompt-pay discount. It occurs when a healthcare provider applies a discount for prompt payment, but the claim does not meet the discount criteria.	1. Communicate to patients about any available prompt-pay discounts and their specific requirements. 2. Train staff on prompt-pay discounts. 3. Implement a technology solution that automatically identifies potential prompt-pay discount opportunities.

CARC 45	It is triggered when the charge for a service exceeds the maximum fee allowed by the payer.	1. Review fee schedules to ensure the rendered service charges are within the contracted fee or maximum allowable arrangement. 2. Verify payer contracts to stay updated on legislated fee limits or specific fee arrangements. 3. Conduct regular audits to identify any potential discrepancies in charge amounts.
CARC 49	It represents that the service is not covered because it is a routine/preventive exam or a diagnostic/screening procedure done with a routine/preventive exam.	1. Ensure accurate documentation indicating whether the service is routine/preventive or diagnostic/screening. 2. Train your staff on the specific requirements of routine/preventive exams and diagnostic/screening procedures. 3. Stay updated on payer policies related to routine/preventive exams and diagnostic/screening procedures.
CARC 50	It happens when the insurance payer does not consider the rendered care services medically necessary.	1. Ensure accurate and complete documentation for the patient's symptoms, diagnosis, treatment plan, and any other relevant information justifying the medical necessity of the rendered care services. 2. Train your staff on specific medical necessity criteria and guidelines for each payer.
CARC 51	This denial code identifies that the rendered care service is not covered due to a pre-existing condition.	1. Verify patient eligibility to identify any pre-existing conditions that may not be covered by the insurance plan. 2. Obtain prior authorization for services related to pre-existing conditions. 3. Ensure accurate documentation for justifying medical necessity when providing services for pre-existing conditions.
CARC 53	It occurs when the insurance provider determines that the services were rendered by a close relative or a household member, in which case the insurance policy does not cover them.	1. Communicate your organization's policy regarding services provided by immediate relatives or members of the same household. 2. Perform the initial screening process before hiring employees to identify any potential conflicts of interest. 3. Implement an effective documentation process identifying the relationship between the patient

		and the provider.
CARC 54	It indicates that multiple physicians/assistants are not covered in this case.	1. Ensure medical records appropriately list all the healthcare providers and assistants involved in the case. 2. Communicate with payers to address any queries or worries about the coverage of several providers and assistants.
CARC 55	This denial code indicates the insurance company considers the procedure/treatment/drug as experimental/investigational.	1. Research to ensure the treatments, procedures, or medications being billed are not considered experimental or exploratory by the insurance company. 2. Provide sufficient documentation to support the medical necessity and efficacy of the treatments, procedures, or medications being billed. 3. Communicate with payers to understand their unique standards for classifying a procedure, medication, or treatment as experimental or investigational.
CARC 56	You may get this denial code when the payer doesn't consider the procedure/treatment effective.	1. Provide adequate documentation of the treatment or procedure, such as supporting evidence, expected outcomes, and purpose. 2. Stay current on insurance payer policies and understand their criteria for determining the efficacy of a treatment or procedure. 3. Collaborate with fellow healthcare providers to gain insights into their experiences regarding the payer requirements for the same treatment or procedure.
CARC 58	It means the treatment was done in the wrong place.	1. Ensure accurate documentation indicating the appropriate PoS where the treatment was provided. 2. Train staff on choosing the correct PoS code. 3. Stay current on changing guidelines and requirements related to PoS codes.
CARC 59	You may receive this denial when your claim contains multiple surgeries or diagnostic imaging procedures performed at the same time or in	1. Ensure accurate documentation indicating the appropriateness and necessity of multiple or concurrent procedures. 2. Use appropriate modifiers to justify the multiple

	close proximity.	or concurrent procedures. 3. Verify medical necessity before rendering multiple or concurrent procedures.
CARC 60	It indicates that outpatient services aren't covered when provided close to inpatient services.	1. Employ a robust scheduling system that allows for an appropriate time gap before or after any inpatient services. 2. Foster a collaborative and information-sharing culture between inpatient and outpatient care departments. 3. Implement an EHR system for seamless information sharing between departments.
CARC 61	This denial code occurs because the healthcare provider did not obtain a second surgical opinion as required.	1. Obtain the necessary second surgical opinions before performing the procedure. 2. Employ an effective referral process streamlining the communication between referring physicians and specialists. 3. Ensure accurate and adequate documentation, including previous treatments, medical history, and the need for seeking second surgical opinions.
CARC 66	It is related to blood deductibles indicating that the payer won't cover the cost of blood transfusions until the deductible is met.	1. Verify insurance eligibility to understand the payer's specific deductible requirements. 2. Communicate to patients their blood deductible and any associated costs upfront. 3. Train your staff on accurate coding guidelines related to blood-related services.
CARC 69	This denial code is triggered when the billed amount for a specific day of service exceeds the expected or usual amount for that particular service.	1. Perform regular audits to spot any potential errors or inconsistencies in your billing and coding workflow and optimize it. 2. Ensure accurate documentation, including the diagnosis, treatment, and other rendered services. 3. Train your staff on payer policies.
CARC 70	It is related to cost outlier indicating the billed amount exceeds a predetermined threshold set by the payer. As a result, an adjustment is necessary to compensate for the additional costs incurred.	1. Ensure accurate and complete documentation, including any additional costs incurred during treatment. 2. Comply with coding guidelines specific to cost outliers. 3. Perform regular audits to identify any patterns

		contributing to cost outliers.
CARC 74	It is related to the Indirect Medical Education Adjustment referring to the additional expenses incurred by teaching hospitals medical residents and interns' training.	1. Ensure accurate documentation related to all medical education activities. 2. Train your staff on coding guidelines related to medical education activities. 3. Stay current with the changing policies related to medical education reimbursement.
CARC 75	It is related to the Direct Medical Education Adjustment indicating the payer has determined that the claimed amount for direct medical education is not eligible for reimbursement or needs further clarification.	1. Ensure accurate documentation, including medical education activities. 2. Comply with guidelines and requirements related to medical education billing. 3. Establish clear communication between the billing and medical education departments.
CARC 76	It is related to Disproportionate Share Adjustment (DSA) indicating additional payment was denied due to certain eligibility criteria not being met.	1. Verify patient eligibility for DSA. 2. Ensure accurate documentation justifying the patient's need for DSA. 3. Train your staff on coding and billing guidelines related to DSA.
CARC 78	You may receive this denial when the number of days or the room charge for a particular service is not covered under the patient's insurance plan.	1. Verify patient eligibility before admitting a patient. 2. Obtain pre-authorization from the payer before rendering services. 3. Ensure accurate documentation justifying the medical necessity of the rendered services.
CARC 85	It is related to Patient Interest Adjustment that is used with Group code PR.	1. Ensure accurate documentation to prevent any discrepancies that could lead to interest adjustments. 2. Submit the claim within the filing deadline to avoid interest adjustments. 3. Verify patient eligibility and benefits to identify issues that may lead to interest adjustments.
CARC 89	This denial code occurs when professional fees are taken out from the charges.	1. Ensure accurate documentation of all professional fees, including procedure details, time spent, and other relevant information. 2. Streamline your coding and billing processes and double-check before submitting to avoid this denial.

CARC 90	It is related to pharmaceuticals indicating ingredient cost adjustment.	1. Ensure accurate documentation related to all pharmaceuticals used. 2. Verify medical necessity before prescribing or administering any pharmaceutical. 3. Perform regular audits to identify discrepancies in pharmaceutical usage documentation.
CARC 91	It is related to dispensing fee adjustment. It may occur due to inadequate documentation, incorrect coding, or exceeding the allowed quantity or frequency of dispensing.	1. Ensure accurate documentation, including diagnosis, medical history, and medications. 2. Verify eligibility before dispensing any medication. 3. Obtain authorization for medications.
CARC 94	This denial occurs when the billed amount is higher than what the payer considers to be reasonable or appropriate for the rendered services.	1. Perform regular audits to ensure accuracy and identify any potential overcharges. 2. Implement effective billing and coding practices to ensure charges align with the services rendered. 3. Employ automated coding software and claim scrubbing tools to identify discrepancies in charges before claim submission.
CARC 95	It occurs when healthcare providers fail to follow proper plan guidelines.	1. Ensure accurate documentation, including treatments, procedures, and the reason behind them. 2. Stay updated with payer policies and guidelines and comply with them. 3. Verify patient eligibility before providing care services.
CARC 96	It is related to non-covered charges indicating missing information in the claim, such as a remark code.	1. Verify patient eligibility to identify any non-covered charges. 2. Obtain authorization before rendering care services. 3. Train your staff on billing and coding guidelines and requirements.
CARC 97	It identifies that the payment for this service is already included in another service that has been processed.	1. Ensure accurate documentation, including justification of medical necessity and distinctiveness of each rendered service. 2. Verify eligibility and benefits to identify if the service is already included in another fee schedule. 3. Communicate with insurance payers to clarify

		any potential overlaps or conflicts in payment.
CARC 100	You may receive this denial when a payment is made directly to the patient, insured individual, or responsible party instead of being processed through the healthcare provider.	1. Verify insurance eligibility to minimize the chances of payments being made directly to the patient or responsible party. 2. Collect accurate and up-to-date insurance information during registration to avoid this denial.
CARC 101	It is related to predetermination, meaning the payment is expected after the completion of the services or the adjudication of the claim.	1. Verify eligibility before rendering care services. 2. Obtain prior authorization for specific services or procedures. 3. Ensure accurate documentation justifying the medical necessity of the rendered services.
CARC 102	It is related to Major Medical Adjustment indicating a claim has been denied or adjusted due to a significant medical reason.	1. Ensure accurate and complete documentation to support medical necessity. 2. Verify eligibility before rendering services. 3. Obtain prior authorization for services from the payer.
CARC 103	It is triggered when a healthcare provider's promotional discount, like a senior citizen discount, is not accepted by the insurance company.	1. Communicate promotional discounts to the patient. 2. Ensure accurate documentation, including discount amount, the reason behind the discount, and other relevant information. 3. Ensure all promotional discounts comply with healthcare regulations and guidelines.
CARC 104	It occurs when a managed care organization (MCO) withholds payment for a healthcare service.	1. Verify patient eligibility with the MCO. 2. Obtain prior authorization for the services from the MCO. 3. Submit claims adhering to MCO's filing timeline and guidelines.
CARC 105	It is related to tax withholding indicating an issue with the provided tax withholding information, such as tax identification number (TIN).	1. Ensure accurate patient information collection for seamlessly reporting tax withholding information. 2. Educate patients about tax withholding requirements. 3. Employ a robust documentation process, including any discussions or agreements related to tax withholding.
CARC 106	You may receive this denial code	1. Educate patients on payment options.

	when the patient's chosen payment option is not in effect.	2. Streamline the payment process enabling easy payment selection. 3. Offer multiple payment options.
CARC 107	You may receive this denial when the claim lacks the necessary information linking it to the related service.	1. Double-check claim information that qualifies it for related service. 2. Use an electronic claim submission tool that flags missing or incorrect information before the claim is submitted. 3. Employ a claim scrubbing tool to automatically review claims for errors or missing information.
CARC 108	It is triggered when the rent or purchase guidelines for a specific healthcare service or item are not met.	1. Comply with all rental or purchase guidelines. 2. Ensure accurate documentation that supports the need for the rental or purchase. 3. Communicate with the insurance company to understand the rental or purchase guidelines.
CARC 109	This denial code identifies that the claim or service is not covered by the payer/contractor and you need to send it to the right one.	1. Verify payer/contractor information before claim submission. 2. Verify patient eligibility to determine the right payer before rendering services. 3. Review contract agreements to determine which services are covered and not covered by the payer.
CARC 110	It is triggered when the billing date is before the service date.	1. Ensure that the billing date accurately reflects the service date. 2. Double-check claims before submitting to reconcile billing and service dates and avoid any discrepancies. 3. Establish clear communication channels between clinical and billing departments.
CARC 111	It means the specific service or procedure is not covered by the insurance unless the healthcare provider agrees to accept the assigned payment amount.	1. Verify patient eligibility before rendering services. 2. Obtain proper authorization for treatments and procedures. 3. Communicate with patients about their insurance coverage and potential out-of-pocket financial responsibility.
CARC 112	It indicates the service was not provided directly to the patient and/or	1. Ensure complete documentation, including the patient's name, service date, and rendered

	not properly documented.	services. 2. Enhance communication between the billing department and the healthcare provider by implementing clear guidelines on documentation requirements. 3. Conduct regular audits of medical records to identify any gaps or inconsistencies in documentation.
CARC 114	This denial code is received when a procedure or product is not approved by the FDA.	1. Research to ensure the product or procedure is approved by the FDA. 2. Use evidence-based practices and treatments that are approved by the FDA. 3. Ensure accurate documentation, including FDA approval status of procedures or products.
CARC 115	It means that the procedure was postponed, canceled, or delayed.	1. Promptly inform all parties of any changes or delays in the scheduled treatment or procedure. 2. Implement scheduling software to minimize the chances of a procedure or treatment being postponed or canceled. 3. Obtain authorization for scheduled services in advance from the payer.
CARC 116	It occurs when the patient's advance indemnification notice doesn't meet the requirements.	1. Ensure that the advance indemnification notice signed by the patient meets all the requirements. 2. Train staff on the specific requirements for the advance indemnification notice.
CARC 117	This denial code indicates that transportation is only covered to the closest facility that can provide the necessary healthcare service.	1. Verify network coverage to ensure the referred facility is within the patient's insurance network. 2. Ensure accurate documentation, including the medical necessity for patients to receive healthcare service at the chosen facility. 3. Communicate with the insurance company to discuss cases where transportation to a specific facility is necessary.
CARC 118	It is related to an adjustment for ESRD (End-Stage Renal Disease) network support.	1. Ensure accurate documentation, including patient eligibility, enrollment, and any changes in their network support status. 2. Verify patient eligibility for ESRD network support.

		3. Comply with billing and coding guidelines related to ESRD network support.
CARC 119	It represents that the maximum benefit for this time period or occurrence has been reached.	1. Verify eligibility to ensure that the patient has not reached their benefit maximum for the specific time period or occurrence. 2. Obtain prior authorization for services to reduce the chances of receiving a denial for reaching the benefit maximum. 3. Educate patients on coverage limits.
CARC 121	It refers to the compensation provided to cover outstanding member responsibility.	1. Educate patients on their financial responsibility. 2. Obtain prior authorization for services from insurance payers. 3. Verify patient eligibility to identify any outstanding member responsibilities.
CARC 122	It is related to a reduction in payment for psychiatric services.	1. Ensure accurate documentation detailing the patient's psychiatric condition and the services provided. 2. Verify eligibility and benefits before rendering psychiatric services. 3. Obtain authorization for psychiatric services from the insurance payer.
CARC 128	This denial code occurs when the services provided for a newborn are covered under the mother's insurance plan.	1. Verify eligibility before providing services to a newborn. 2. Ensure accurate documentation, including the mother's insurance details, the newborn's date of birth, and any other supporting details. 3. Communicate with the payer to understand where the newborn's services are covered under the mother's allowance.
CARC 129	It occurs when there is incorrect prior processing information and at least one Remark Code must be provided.	1. Ensure accurate prior processing to verify the NCPDP Reject Reason Code or Remittance Advice Remark Code and ensure it is not an ALERT. 2. Conduct regular audits to identify discrepancies in the prior processing information.
CARC 130	It is related to the claim submission	1. Implement an automatic claim submission

	fee indicating that the provider has not paid it.	system to ensure that all required fields are accurately filled. 2. Conduct regular audits to identify any potential issues related to submission fees. 3. Train staff on how to prevent denials related to submission fees.
CARC 131	You may receive this denial code when your claim requests a specific discount that is not allowed as per the terms of the agreement between the insurance company and the healthcare provider.	1. Regularly review payer contracts to understand all negotiated discounts with payers. 2. Verify eligibility to understand whether the negotiated discount is applicable or not.
CARC 132	It means a prearranged demonstration project requirement or guideline is not met.	1. Ensure accurate documentation, including the purpose and outcomes of any demonstration projects. 2. Comply with billing and coding guidelines related to demonstration project adjustments. 3. Stay current on payer policies related to demonstration project adjustments.
CARC 133	It is triggered when the disposition of a service line is pending further review.	1. Ensure accurate documentation, including the patient's condition, treatment, and other relevant information. 2. Conduct regular audits to identify any potential issues or discrepancies in the coding and billing process.
CARC 134	This denial code indicates that the technical fees are removed from the charges, and the payer will not reimburse it.	1. Ensure accurate documentation, including details of all technical components of a service or procedure, such as supplies used or equipment usage. 2. Comply with coding guidelines related to the usage of technical components. 3. Train staff on how to prevent denials related to technical fees.
CARC 135	This denial code indicates that interim bills cannot be processed.	1. Submit interim bills within the filing timeframe to avoid processing delays. 2. Ensure accurate documentation before submitting interim bills. 3. Communicate with the insurance company to resolve issues related to interim bills.

CARC 136	It occurs when you fail to follow the coverage rules set by the previous payer. It is used with Group Code OA.	1. Verify prior authorization requirements from the payer before rendering services. 2. Accurately document prior authorization in the patient's medical record. 3. Stay current on any changes in prior payer policies and coverage rules.
CARC 137	You may receive this denial code when regulatory surcharges, health-related taxes, allowances, or assessments are not approved for reimbursement.	1. Stay current on changes in regulatory surcharges, health-related taxes, allowances, or assessments. 2. Ensure accurate documentation related to regulatory surcharges, health-related taxes, allowances, or assessments. 3. Comply with coding guidelines related to regulatory surcharges, health-related taxes, allowances, or assessments.
CARC 139	It is triggered when the subscriber receiving healthcare services is employed by the healthcare provider. It is used with Group Code CO.	1. Verify employment status to identify the subscriber's employer. 2. Review the contracted funding agreement between the subscriber's employer and the provider. 3. Ensure accurate documentation, including the subscriber's employment status and any changes over time.
CARC 140	It indicates that the patient or insured person's health identification number and name do not match.	1. Verify the patient's health identification number and double-check to ensure it matches their record. 2. Confirm the patient's name with the name on their official documents and insurance card. 3. Communicate with the payer if there is a discrepancy between the health identification number and the patient's name.
CARC 142	It is triggered when the monthly Medicaid patient liability amount is not being met.	1. Verify patient eligibility before providing services to a Medicaid patient. 2. Ensure that information, including their Medicaid identification number, is accurately recorded in the medical records. 3. Communicate with the patient about their financial responsibility.
CARC 143	It occurs when a portion of the	1. Ensure accurate documentation justifying the

	payment has been deferred, i.e., the payer delays or holds back a certain amount of the payment for a specific reason.	requested payment for the rendered services. 2. Verify eligibility to avoid situations where the payment is deferred due to lack of coverage. 3. Comply with coding guidelines to avoid misinterpretation by the insurance payer.
CARC 144	This denial code is triggered due to an incentive adjustment, such as a preferred product or service.	1. Ensure accurate documentation, including all relevant information, such as the specific brand or model of the preferred product or service. 2. Verify eligibility to determine if there are any restrictions or limitations on preferred products or services. 3. Obtain prior authorization for preferred products or services.
CARC 146	It indicates that the diagnosis reported for the service date(s) is invalid.	1. Ensure accurate documentation, including verification that the diagnosis code matches the date(s) of service and that it is supported by the medical records. 2. Conduct regular audits to identify potential issues related to the date(s) of service and diagnosis code.
CARC 147	You may receive this denial code when the provider's negotiated rate has expired or is not on file.	1. Regularly review and update provider contracts to ensure they contain all negotiated rates. 2. Maintain accurate and updated fee schedules for each provider. 3. Employ a robust contract management system to track and manage all provider contracts.
CARC 148	It occurs when information from another healthcare provider was either not provided or was insufficient/incomplete.	1. Communicate with other healthcare providers, establishing a network to ensure accurate and prompt information sharing. 2. Train staff on the importance of accurate and complete documentation. 3. Implement EHR with built-in checks and alerts to ensure all necessary information is complete before submitting a claim.
CARC 149	It is triggered when the lifetime benefit maximum reaches a service/benefit category.	1. Verify patient eligibility for lifetime benefit maximum for the specific service or benefit category. 2. Communicate with patients about the possibility of reaching their lifetime benefit

		maximum. 3. Use alternative services if a patient has reached their lifetime benefit maximum for a particular service or benefit category.
CARC 150	You may receive this denial code when the payer believes the information provided does not justify the level of service.	1. Ensure accurate and complete documentation, including the patient's medical history, examination findings, symptoms, and treatment provided, to support the level of service. 2. Comply with coding guidelines to avoid the likelihood of this denial. 3. Train staff on the consequences of inadequate or missing documentation.
CARC 151	It identifies that the information provided does not justify the number or frequency of services.	1. Ensure accurate documentation, including the medical necessity, duration, and frequency of the services provided. 2. Verify eligibility to determine any limitations or restrictions that apply to the frequency of services. 3. Communicate with the payer if you believe that the services provided are medically necessary.
CARC 152	It occurs when the information provided fails to justify the length of service.	1. Ensure accurate and adequate documentation justifying the need for the specific length of service. 2. Conduct regular audits to proactively address any deficiencies and implement corrective measures to prevent this denial. 3. Train staff on necessary documentation and coding guidelines.
CARC 153	It identifies that the information provided in the claim fails to justify the prescribed dosage.	1. Ensure accurate and adequate documentation justifying the prescribed dosage. 2. Conduct regular audits to identify gaps or inconsistencies in documentation. 3. Communicate with prescribers to prevent denials related to the prescribed dosage.
CARC 154	It indicates that the information provided fails to justify the amount of medication or supplies for that day.	1. Ensure accurate and adequate documentation justifying the day's supply of services or medications. 2. Verify eligibility to ensure the specific day's supply is covered by the insurance company.

		3. Stay current on payer policies related to the day's supply.
CARC 155	It is triggered when the patient refuses to receive a specific service or procedure.	1. Communicate with patients to ensure they understand the benefits of the recommended service or procedure. 2. Actively involve patients in their healthcare decisions. 3. Ensure accurate documentation, including conversations, discussions, and attempts to persuade the patient.
CARC 157	This denial code indicates that a service or procedure was provided as a result of an act of war.	1. Review patient records to identify if services or procedures may have been provided as a result of an act of war. 2. Ensure accurate documentation, including the reason for the service or procedure, stating why it was not a result of an act of war. 3. Train your staff on the necessary precautions to avoid situations where services or procedures may be mistakenly attributed to an act of war.
CARC 158	It occurs when the service/procedure is provided outside of the US.	1. Verify insurance coverage to ensure the patient is eligible for healthcare services within the US. 2. Educate staff on coverage limitations. 3. Obtain prior authorization for services that are likely to be performed outside of the US.
CARC 159	You may receive this denial code when services/procedures are performed due to terrorism.	1. Perform patient screening before rendering services, such as verifying patient identities and suspicious activities or affiliations, and report any suspicious findings. 2. Train staff on signs and indicators of potential terrorism-related activities. 3. Stay updated on security protocols provided by relevant authorities.
CARC 160	It indicates that injuries/illnesses are caused by activities not covered by insurance.	1. Verify eligibility to ensure the specific activity or treatment is covered under their plan. 2. Obtain prior authorization for services that may be considered a benefit exclusion. 3. Ensure accurate documentation, including the nature of the injury or illness and the activity that led to it.

CARC 161	You may receive this denial code if the claim contains a provider performance bonus that the payer denied for reimbursement.	1. Ensure accurate documentation to support medical necessity. 2. Comply with coding guidelines to ensure the assigned codes reflect the rendered services accurately. 3. Perform regular audits to identify and rectify potential issues leading to denials.
CARC 163	This denial code identifies that the requested documents for the claim were not received.	1. Ensure accurate documentation with supporting information and necessary attachments. 2. Implement electronic document management systems to ensure that all required documentation is submitted. 3. Communicate with the payer to understand the document requirements.
CARC 164	It indicates that the requested documents for the claim were not received on time.	1. Ensure accurate documentation with supporting information and necessary attachments are submitted within the deadline. 2. Implement electronic document management systems to track the required documentation is complete. 3. Communicate with the payer to understand the document requirements and filing timeframe.
CARC 166	It occurs when services are submitted after the payer's responsibility for processing claims under the plan has ended.	1. Ensure timely claim submission. 2. Communicate with insurance payer to stay informed about the changes in their claim processing timelines. 3. Implement technology solutions that offer automated reminders for claim submission deadlines.
CARC 167	This denial code means that the diagnosis mentioned in the claim is not covered by the payer.	1. Ensure accurate documentation, including all diagnoses and their supporting information. 2. Verify eligibility to identify potential exclusions and limitations. 3. Stay current on changes in payer policies and guidelines.
CARC 169	It is related to alternate benefits. It is triggered when the payer has determined that a different service or	1. Verify eligibility before rendering care services. 2. Obtain pre-authorization to obtain this approval before providing the service to avoid

	treatment is more appropriate or cost-effective for the patient's condition.	denials based on alternate benefits. 3. Communicate with the payer when you receive alternate benefits to understand the reason behind it.
CARC 170	You may receive this denial code when the payer identifies that the services are performed or billed by a healthcare provider not authorized to provide that specific type of service.	1. Focus on proper provider credentialing, such as verifying their qualifications, licenses, and certifications to ensure they are authorized to provide specific services. 2. Communicate with payers to understand their specific requirements for provider types. 3. Ensure accurate documentation to prevent any confusion or misinterpretation by payers.
CARC 171	It means payment is denied for services provided by a specific type of provider in a specific type of facility.	1. Ensure proper provider and facility type to prevent this denial code. 2. Verify payer requirements for provider and facility type eligibility. 3. Provide complete documentation supporting the provider's qualifications and the facility type for rendered services.
CARC 172	This denial code is triggered when the payment for a service is adjusted because it was performed or billed by a provider who is not specialized in that particular service.	1. Comply with coding guidelines to ensure the provider's specialty aligns with the services provided. 2. Verify provider credentials to ensure the provider's specialty matches the billed services. 3. Ensure accurate documentation to support medical necessity and the provider's specialty.
CARC 173	It occurs when a physician does not prescribe the service or equipment.	1. Ensure accurate documentation, including the physician's prescription or order for the specific service or equipment. 2. Communicate with the physicians to ensure they understand the necessary documentation requirements. 3. Obtain pre-authorization to ensure the service or equipment is medically necessary and prescribed by a physician.
CARC 174	It happens when a healthcare service or treatment was not prescribed by a healthcare provider before it was delivered to the patient.	1. Ensure that all services are properly prescribed before delivery. 2. Providers should establish effective communication channels with referring

		physicians. 3. Train staff on the importance of obtaining prescriptions and following proper protocols.
CARC 175	You may receive this denial code for an incomplete prescription.	1. Ensure accurate and complete documentation, including the patient's name, date of birth, medication name, dosage, frequency, and duration. 2. Utilize standardized prescription templates to ensure that all required information is included. 3. Implement customization in prescription templates to include specific fields for different medications or treatment types.
CARC 176	It indicates that the provided prescription is not current.	1. Review and update patient prescriptions to ensure they reflect their current medical condition. 2. Implement electronic prescribing systems to reduce the chances of errors or outdated prescriptions. 3. Communicate with patients to ensure they understand the importance of keeping their prescriptions current.
CARC 177	It occurs when the patient fails to meet the eligibility criteria.	1. Verify eligibility to ensure the patient meets the requirements, such as prior authorization, medical condition, or age. 2. Educate patients on eligibility requirements. 3. Conduct regular eligibility checks to ensure the patient still meets the requirements before providing services.
CARC 178	It identifies a situation where the patient has not fulfilled the necessary spend-down requirements.	1. Verify eligibility to ensure the patient has met the required spend-down requirements. 2. Educate patients on spend-down requirements. 3. Offer financial counseling to patients struggling to meet the spend-down requirements.
CARC 179	It means the patient hasn't fulfilled the waiting requirements.	1. Ensure accurate documentation to prevent any confusion or discrepancies. 2. Educate staff on the waiting requirements for different procedures or services. 3. Implement a system of automated reminders to notify patients about their waiting

		requirements.
CARC 180	This denial code is triggered when the patient does not meet the necessary residency requirements.	1. Verify patient residency. 2. Educate patients on residency requirements. 3. Implement an EHR system with built-in residency verification tools or utilize standardized forms to collect the necessary information.
CARC 181	It happens when the procedure code used is invalid on the date of service.	1. Comply with coding guidelines to ensure all procedure codes are valid and current. 2. Conducting regular audits to identify any potential coding errors or discrepancies. 3. Train staff on coding guidelines and regulations.
CARC 182	It occurs when the procedure modifier used on the date of service is invalid.	1. Ensure all procedure modifiers are documented and recorded for each service date. 2. Educate staff on coding guidelines, including modifier usage. 3. Foster effective communication channels between departments, such as coders, billers, and clinical staff.
CARC 183	It indicates the referring provider is not authorized to refer the billed service.	1. Verify the provider is eligible to refer the specific billed service. 2. Maintain accurate provider records and update any changes in provider eligibility or authorization promptly. 3. Implement internal checks to verify the referring provider's eligibility before submitting the claim.
CARC 184	It means the provider is not authorized to prescribe the service.	1. Ensure the provider is eligible to prescribe or order the billed service. 2. Maintain accurate provider information and update any changes in their credentials or authorization status. 3. Educate providers on eligibility requirements.
CARC 185	It occurs when the provider is not allowed to perform the billed service.	1. Ensure the provider is eligible to perform the billed service. 2. Conduct regular audits to identify any potential issues or discrepancies before submitting claims. 3. Communicate with the payer to clarify any

		questions or concerns regarding provider eligibility.
CARC 186	It is related to the level of care change adjustment. It means there is a change in the level of care provided to the patient.	1. Ensure accurate documentation, including any changes in the patient's condition that may warrant a level of care change. 2. Foster effective communication between healthcare providers, case managers, and billing staff. 3. Utilize standardized protocols to ensure consistency and compliance with payer requirements.
CARC 187	It is related to Consumer Spending Account payments, which can include various types of accounts such as Flexible Spending Accounts (FSA), Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA), etc.	1. Verify eligibility to ensure the patient's Consumer Spending Account is active and covers the rendered services. 2. Obtain pre-authorization from the Consumer Spending Account administrator. 3. Ensure accurate documentation justifying the billed services and provide evidence in case of a denial.
CARC 188	It occurs when a product or procedure is not covered because it is not used as per the recommendations set forth by the FDA.	1. Ensure accurate documentation, including clinical notes, test results, and any relevant FDA guidelines. 2. Stay current on FDA recommendations. 3. Implement pre-authorization checks to identify any potential issues leading to this denial.
CARC 189	It means a procedure or service was billed using a "not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) when there is a specific procedure code available for that particular procedure or service.	1. Stay current on the latest coding guidelines. 2. Avoid using "not otherwise classified" or "unlisted" codes unless there is no specific code available. 3. Conduct regular audits to identify and address any coding errors or knowledge gaps through additional training and education.
CARC 190	It is triggered when the payment for a service or treatment is already included in the allowance provided for a qualified stay at a Skilled Nursing Facility (SNF).	1. Ensure accurate documentation related to the patient's stay at an SNF. 2. Verify eligibility before admitting a patient to the SNF. 3. Conduct regular utilization reviews to determine the medical necessity of the patient's stay at the SNF.

CARC 192	It is a non-standard adjustment code used by providers/payers to provide Coordination of Benefits information to another payer.	1. Ensure accurate documentation to prevent non-standard adjustment codes from paper remittance. 2. Use claims management software to mitigate the risk of encountering non-standard adjustment codes. 3. Perform regular audits to identify and rectify issues that may lead to non-standard adjustment codes.
CARC 193	It is triggered when the original payment decision is being maintained because the claim was processed correctly.	1. Ensure accurate and complete documentation because the main reason behind this denial code is insufficient documentation. 2. Verify coding accuracy to avoid getting this denial. 3. Stay current on the changes in payer policies or guidelines.
CARC 194	You may receive this denial code when the anesthesia is performed by either the operating physician, the assistant surgeon, or the attending physician.	1. Ensure accurate documentation specifying who performed anesthesia, specific procedures, and start and end times. 2. Verify medical necessity before providing anesthesia services. 3. Comply with coding guidelines to ensure correct codes are used for anesthesia services.
CARC 195	This code occurs when a refund is mistakenly given to the wrong payer for a claim or service.	1. Double-check payer information before claim submission. 2. Ensure accurate patient demographic information. 3. Review each claim before submission for inconsistencies that may result in incorrect payment or denial.
CARC 197	It means that the precertification, authorization, notification, or pre-treatment is missing.	1. Obtain all necessary pre-certifications, authorizations, notifications, or pre-treatment requirements before rendering services. 2. Communicate with payers on their specific pre-authorization requirements. 3. Train staff on pre-authorization requirements.
CARC 198	It indicates that the precertification, notification, authorization, or pre-treatment requirements have been	1. Obtain pre-certifications, notifications, authorizations, or pre-treatment requirements before rendering services.

	exceeded.	2. Communicate with payers to understand their specific pre-authorization requirements. 3. Train staff on pre-authorization requirements.
CARC 199	This denial code indicates that the revenue code and procedure code submitted for a healthcare service do not match.	1. Conduct regular audits to ensure revenue codes and procedure codes to ensure they match accurately. 2. Improve documentation to prevent any confusion or mismatch between the codes. 3. Train staff on the importance of accurate code matching and reduce the likelihood of errors.
CARC 200	It occurs when expenses are not covered due to a lapse in insurance coverage.	1. Verify eligibility to ensure the patient has active coverage. 2. Educate patients on insurance responsibilities. 3. Timely follow-up on unpaid premiums if a patient's coverage lapses.
CARC 201	It means the patient is responsible for the claim amount due to an agreement.	1. Verify eligibility for potential issues or agreements, such as a "set aside arrangement". 2. Educate patients on their financial responsibilities and any agreements they have in place. 3. Ensure accurate documentation, including any agreements or arrangements made with the patient.
CARC 202	You may receive this denial code when the claim contains services that are not covered by insurance, such as personal comfort or convenience services.	1. Ensure accurate documentation to support medical necessity. 2. Verify eligibility to identify potential limitations or exclusions for personal comfort or convenience services. 3. Train staff to ensure they understand the specific criteria for personal comfort or convenience services.
CARC 203	It occurs when the rendered service is discontinued or reduced.	1. Ensure accurate documentation to justify the medical necessity. 2. Communicate with patients and payers to update on any changes in treatment plans or services. 3. Obtain prior authorization before providing any services that may be subject to discontinuation or reduction.

CARC 204	This denial code is triggered when a service, equipment, or drug is not covered by the patient's insurance plan.	1. Verify eligibility to ensure the service, equipment, or drug is covered under their current plan. 2. Obtain prior authorization for specific services, equipment, or drugs. 3. Ensure that the service, equipment, or drug is medically necessary for the patient's condition.
CARC 205	It is related to the processing fee of a pharmacy discount card.	1. Verify patient eligibility before processing any pharmacy discount card. 2. Train staff on discount card policies. 3. Double-check card information when processing a pharmacy discount card.
CARC 206	It means the National Provider Identifier (NPI) is missing.	1. Ensure accurate and up-to-date provider information. 2. Utilize automated NPI validation checks in your billing and claims submission processes. 3. Train staff to include the NPI in all relevant claim forms and electronic transactions.
CARC 207	It indicates an invalid format of the National Provider Identifier (NPI).	1. Double-check the NPI entered into the system to ensure it is in the correct format. 2. Utilize automated validation checks within your billing software to verify the format of the NPI before claim submission. 3. Train staff on the correct format of the NPI.
CARC 208	It occurs when the National Provider Identifier (NPI) does not match.	1. Ensure accurate and up-to-date provider information, and verify NPI in the billing system match the provider's information on file. 2. Utilize automated software to validate NPIs in real time to ensure they are correctly formatted and match the provider's information. 3. Conduct regular audits to identify missing or incorrect NPIs.
CARC 209	You receive this denial code when you cannot collect a certain amount from the patient due to regulatory or other agreements. You can bill this amount to another payer. However, if collected, it must be refunded to the patient. It is used with group code OA.	1. Verify eligibility to mitigate the risk of receiving denials related to regulatory or agreement issues. 2. Obtain prior authorization to prevent denials related to regulatory or agreement issues. 3. Ensure accurate documentation, including diagnosis codes, procedure codes, and any

		supporting information.
CARC 210	It means payment was adjusted because pre-certification/authorization was not received on time.	1. Communicate with the payer to ensure that pre-certification requirements are clearly understood and followed. 2. Leverage the EHR system to streamline the pre-certification process. 3. Train staff on the pre-certification process.
CARC 211	You may receive this denial code when National Drug Codes (NDC) are not eligible for rebates and, therefore, are not covered by the insurance provider.	1. Verify NDC eligibility and cross-reference it with the payer's formulary or preferred drug list before submitting a claim. 2. Use appropriate modifiers to indicate the eligibility of a drug for rebate or coverage. 3. Stay updated with the payer's policies regarding NDC eligibility.
CARC 212	It is triggered when the administrative surcharges associated with the healthcare service are not covered by the insurance policy.	1. Verify eligibility to identify if administrative surcharges are covered. 2. Communicate with patients about any potential administrative surcharges that may not be covered by their insurance. 3. Ensure accurate documentation, including administrative surcharges and supported documentation.
CARC 213	It indicates that the provider failed to follow the rules about referring patients to other physicians or facilities according to the law or the insurance company's policy.	1. Train physicians and staff on physician self-referral prohibition legislation and payer policies. 2. Implement rigorous compliance policies to prevent violation of physician self-referral prohibition legislation. 3. Perform regular audits to identify any potential violations of the physician self-referral prohibition legislation.
CARC 215	It identifies that the healthcare provider has already received payment from a third party through subrogation.	1. Ensure accurate documentation, including insurance details and any third-party involvement. 2. Verify all patients' eligibility, especially those involved in third-party settlements. 3. Communicate with patients, insurance companies, and any third parties involved in the settlement.

CARC 216	You may receive this denial code when a review organization determines that the claim does not meet the requirements for reimbursement.	1. Ensure accurate documentation supporting medical necessity for the rendered care services. 2. Stay current on coding guidelines to ensure compliance with review organization requirements. 3. Conduct regular audits to identify trends that may result in denials based on review organization findings.
CARC 219	It means adjustment is based on the extent of injury. Providers should refer to the insurance policy number or healthcare policy identification for jurisdictional regulations.	1. Ensure accurate documentation to accurately reflect the extent of the injury. 2. Comply with coding guidelines to ensure accurate code assignment and reduce the likelihood of this denial. 3. Stay current on different payer policies and guidelines.
CARC 222	It means the provider has exceeded the agreed limit for hours/days/units.	1. Review and update provider contracts to define the maximum number of hours, days, or units that can be billed within a specific period. 2. Implement a tracking system to monitor the utilization of services provided by each provider. 3. Prioritize pre-authorization and referrals before providing services that may exceed the contracted limits.
CARC 223	It occurs when an adjustment is required due to a federal, state, or local law/regulation not covered by any other existing code.	1. Stay current on federal, state, and local laws and regulations that impact your healthcare facility. 2. Perform regular audits to ensure your facility is complying with mandated laws and regulations. 3. Foster a culture of collaboration and communication between compliance officers, coders, billers, and other relevant stakeholders.
CARC 224	It identifies that the patient's identification has been compromised due to identity theft.	1. Utilize patient identification protocols to prevent identity theft. 2. Enhance data security measures to protect patient data. 3. Train staff on identity theft prevention.
CARC 225	It means the insurance company has	1. Verify eligibility to identify potential issues or

	made a penalty or interest payment. It is used for plan-to-plan encounter reporting within the 837.	limitations that may result in a penalty or interest payment. 2. Communicate with the payer to address any questions or concerns regarding the encounter. 3. Stay current on payer policies to understand their specific requirements for plan-to-plan encounter reporting within the 837.
CARC 226	This denial code is triggered when the billing provider fails to provide the requested information on time or the provided information is incomplete.	1. Ensure timely and complete submission of information. 2. Review and double-check documentation to ensure that it is complete and accurate. 3. Communicate with the billing/rendering provider to ensure that any requested information is provided promptly.
CARC 227	It identifies that the patient or responsible party did not provide enough or complete information.	1. Communicate with the patient to ensure that all necessary information is collected accurately and completely. 2. Utilize online portals and electronic forms to ensure that all necessary information is captured. 3. Train staff on collecting complete and accurate patient information.
CARC 228	It indicates that the provider, another provider, or the subscriber did not provide the necessary information to a previous payer for review.	1. Communicate with the payer to address any information requests promptly. 2. Streamline the documentation process to ensure timely submission of all required information to the previous payer. 3. Verify the provided information to the previous payer for accuracy and completeness.
CARC 229	It occurs when Medicare doesn't consider a partial charge due to the claim type of 12X.	1. Submit claims with the correct type of bill. 2. Verify patient eligibility with Medicare before submitting the claim. 3. Ensure accurate documentation to prevent this denial.
CARC 231	It means that certain procedures cannot be performed on the same day or in the same setting.	1. Prioritize scheduling to ensure mutually exclusive procedures are not scheduled on the same day or in the same setting. 2. Establish effective communication channels between healthcare providers and staff

		involved in scheduling and performing procedures. 3. Utilize an EHR system for automatic alerts and reminders for staff regarding mutually exclusive procedures.
CARC 232	It is specific to institutional claims. It indicates the reason for the difference in the Diagnosis-Related Group (DRG) amount when a patient's care spans multiple institutions.	1. Ensure accurate patient information, including the patient's previous institutional history and any transfers that may have occurred. 2. Establish clear communication channels between institutions to avoid discrepancies in the DRG amount. 3. Standardize documentation to minimize errors and discrepancies in the DRG amount.
CARC 233	It is related to services or charges that are associated with the treatment of a hospital-acquired condition or a preventable medical error.	1. Implement infection control protocols to minimize the occurrence of hospital-acquired conditions. 2. Train staff on how to prevent medical errors and hospital-acquired conditions. 3. Utilize an EHR system to reduce the occurrence of preventable medical errors.
CARC 234	You may receive this denial code when a procedure is not eligible for a separate payment.	1. Comply with coding guidelines to accurately reflect the services provided. 2. Train your staff on coding guidelines, payer policies, or industry regulations. 3. Verify medical necessity before rendering care services.
CARC 235	It is related to sales tax. It is triggered because it includes charges for sales tax, which are not eligible for reimbursement according to the payer's policies.	1. Utilize a billing system with built-in tax calculation capabilities to prevent denials related to sales tax. 2. Conduct regular audits to identify any potential issues or discrepancies related to sales tax. 3. Ensure accurate documentation, including sales tax amount, the applicable tax rate, and any exemptions or exceptions that may apply.
CARC 236	It occurs when a procedure or combination of procedures is not compatible with another procedure or combination provided on the same day.	1. Ensure that all necessary pre-authorization requirements are met. 2. Utilize effective scheduling practices to avoid situations where incompatible procedures or procedure/modifier combinations are

		performed on the same day.
CARC 237	It is related to a legislated or regulatory penalty and indicates that one remark code is needed.	1. Ensure accurate documentation, including submitting the appropriate NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT. 2. Train your staff to ensure they are well-versed in the legislated or regulatory guidelines. 3. Collaborate with insurance companies to clarify any uncertainties or questions regarding the legislated or regulatory guidelines.
CARC 238	You may receive this denial code when a claim spans both eligible and ineligible periods of coverage, indicating that the claim is reduced for the ineligible period. It is used with group code PR.	1. Verify patient eligibility for the entire period of service. 2. Ensure timely claim submission because delays may increase the chances of the claim spanning both eligible and ineligible periods. 3. Educate patients on maintaining continuous coverage and inform them about the potential consequences of having an ineligible period.
CARC 239	It means the claim covers both eligible and ineligible periods. Separate claims need to be rebilled.	1. Rebill separate claims when a claim spans both eligible and ineligible periods of coverage. 2. Educate patients on maintaining continuous coverage and inform them about the potential consequences of having an ineligible period.
CARC 240	It is triggered when the diagnosis does not match the patient's birth weight.	1. Ensure accurate documentation, including the patient's birth weight. 2. Conduct regular audits to address any issues related to birth weight discrepancies. 3. Educate staff on specific coding guidelines related to birth weight.
CARC 241	It is for the Low Income Subsidy (LIS) co-payment amount in healthcare billing.	1. Verify patient eligibility for the Low Income Subsidy (LIS) program. 2. Educate patients on co-payment requirements who are eligible for the LIS program. 3. Train staff on LIS program guidelines.
CARC 242	It identifies that services are not provided by networks or primary care providers.	1. Train staff on the network's policies and guidelines. 2. Improve communication between the healthcare providers and the patients.

		3. Implement a utilization review process to evaluate the medical necessity of services before rendering.
CARC 243	It means services were not approved by your network or primary care providers.	1. Verify network coverage before providing services. 2. Obtain prior authorizations to prevent denials related to unauthorized network services. 3. Educate patients on network restrictions.
CARC 245	It is related to the Provider Performance Program withhold, indicating the provider's performance failed to meet the required standards or criteria set by the program.	1. Ensure accurate documentation to avoid this denial code. 2. Monitor and analyze denial trends to take preventive measures. 3. Understand the required standards or criteria set by the program.
CARC 246	It is a non-payable code used for required reporting purposes only. It indicates the denial is not related to any specific issue with the services provided or the billing process.	1. Check for missing or incomplete details that may have triggered the non-payable code. 2. Verify coding accuracy to identify potential errors or discrepancies that could have led to the non-payable code. 3. Ensure accurate documentation justifying the medical necessity.
CARC 247	You may receive this denial code when the deductible for a professional service is billed on an institutional claim in a healthcare setting.	1. Ensure accurate documentation, including the specific location for rendered service, and indicate that it was performed in an institutional setting. 2. Train staff on coding guidelines for services rendered in an institutional setting. 3. Collaborate with payers to understand their specific requirements for services rendered in an institutional setting.
CARC 248	It means the coinsurance for a professional service was rendered in an institutional setting and billed on an institutional claim.	1. Ensure accurate documentation for services rendered in an institutional setting. 2. Train staff on the specific requirements for billing services rendered in an institutional setting. 3. Conduct regular audits to identify issues related to services rendered in an institutional setting.
CARC 249	It is for claims identified as	1. Ensure that patients receive proper education

	readmissions. It is used with group code CO.	and resources before leaving the hospital to reduce the likelihood of readmission. 2. Conduct thorough patient pre-admission assessments. 3. Leverage data analytics tools to identify patterns and trends related to readmissions.
CARC 250	You may receive this denial code when the attachment or other documentation that was submitted is incorrect or missing.	1. Double-check attachments to ensure the attachment or other documentation is correct. 2. Communicate with the payer to understand their specific requirements for attachments or documentation. 3. Train staff on the importance of accurate and complete documentation.
CARC 251	It is triggered when the documentation submitted is incomplete and more information is needed to process the claim.	1. Ensure accurate documentation and double-check all attachments before submission. 2. Review claim requirements, including any specific formats or documentation needed. 3. Train staff on documentation requirements.
CARC 252	It occurs when an attachment is needed to process this claim.	1. Ensure accurate documentation, including medical records, test results, or other relevant documents. 2. Review coding guidelines to ensure that all required codes and documentation are included. 3. Utilize a claim management system with built-in checks to ensure all required documentation is included before claim submission.
CARC 253	It is related to a reduction in federal payment known as sequestration.	1. Stay updated with changes in federal payment policies. 2. Ensure accurate and timely documentation to prevent denials related to sequestration. 3. Monitor claims and remittance advice to identify any denials related to sequestration.
CARC 254	This denial code occurs when a claim is received by the dental plan, but the benefits for the services provided are not available under that specific plan.	1. Verify eligibility to ensure rendered services are covered under the dental plan. 2. Inform patient about their dental plan coverage limitations. 3. Obtain pre-authorization for services not covered under the dental plan.

CARC 256	It indicates that a healthcare provider's service is not covered by a managed care contract, resulting in non-payment.	1. Review managed care contracts to identify the specific services that are not payable. 2. Obtain prior authorization for specific services from the payer. 3. Verify eligibility before providing services.
CARC 257	You may receive this denial when a claim or service is not determined during the grace period for premium payment.	1. Ensure that premium payments are made within the designated grace period. 2. Educate patients on timely premium payments and the potential consequences of non-payment. 3. Regularly monitor premium payments to identify any issues or discrepancies.
CARC 258	It means that the claim or service is not covered because the patient is in custody or incarcerated.	1. Verify the patient's custody or incarceration status before rendering services. 2. Obtain necessary documentation, including a letter from the patient's legal representative or relevant authorities stating the patient's status. 3. Review payer policies regarding patients in custody or incarceration.
CARC 259	It indicates that the claim for additional payment for dental or vision services has been denied.	1. Ensure accurate documentation, including details about specific dental or vision services. 2. Verify insurance coverage before providing dental or vision services. 3. Obtain prior authorization for certain dental or vision services.
CARC 260	You may receive this denial code when a claim is processed under the Medicaid ACA Enhanced Fee Schedule and is not approved for payment.	1. Verify the patient's Medicaid eligibility before providing services. 2. Stay up-to-date with Medicaid policies. 3. Train staff on the Medicaid program's timely filing limits.
CARC 261	It means the procedure or service does not match the patient's medical history.	1. Review the patient's medical history before performing any procedure or service. 2. Conduct pre-authorization checks before providing any non-emergency procedure or service. 3. Train staff on preventing this denial.
CARC 262	It is an adjustment for delivery cost, used specifically for pharmaceuticals.	1. Ensure accurate documentation for all pharmaceutical deliveries.

		2. Verify the patient's eligibility and coverage for the specific medication before delivering pharmaceuticals. 3. Train staff on proper documentation and coding practices for pharmaceutical deliveries.
CARC 263	It is an adjustment for shipping costs, used specifically for pharmaceuticals.	1. Ensure accurate documentation for all shipping costs related to pharmaceuticals. 2. Comply with payer guidelines related to shipping costs for pharmaceuticals.
CARC 264	It is an adjustment for postage cost, used specifically for pharmaceuticals.	1. Ensure accurate documentation, including the specific pharmaceuticals and their associated postage costs. 2. Verify patient eligibility and coverage for pharmaceuticals. 3. Conduct regular audits to identify any discrepancies related to adjustment for postage costs.
CARC 265	It is an adjustment for administrative costs, used specifically for pharmaceuticals.	1. Ensure accurate documentation, including the necessity and appropriateness of the medication. 2. Verify insurance coverage before prescribing or administering pharmaceuticals. 3. Stay updated with payer policies regarding pharmaceutical coverage.
CARC 266	It is an adjustment for the cost of compound preparations in healthcare billing, specifically used for pharmaceuticals.	1. Ensure accurate documentation, including the specific pharmaceuticals used and their associated costs. 2. Verify the medical necessity of the compound preparation before claim submission. 3. Stay current on payer requirements related to reporting compound preparation costs.
CARC 267	It means that the claim or service being submitted spans multiple months, and it requires at least one remark code to be provided.	1. Ensure accurate and timely documentation, justifying the need for spanning the claim/service across multiple months. 2. Use appropriate coding modifiers to indicate the span of the service. 3. Review and validate claims, including any required remark codes before claim submission.

CARC 268	It occurs when a claim spans two calendar years. It means that the claim needs to be resubmitted as separate claims, with one claim for each calendar year.	1. Submit separate claims for services provided in different calendar years. 2. Submit claims promptly to avoid the claim crossing over into a new calendar year. 3. Double-check the service date on the claim to ensure it aligns with the correct calendar year.
CARC 269	It identifies that anesthesia is not covered for the service/procedure.	1. Verify coverage before providing anesthesia services. 2. Obtain prior authorization where anesthesia may not be automatically covered. 3. Stay updated with payer policies regarding anesthesia coverage.
CARC 270	You may receive this denial when the benefits for the services provided are unavailable under that specific medical plan, and you should submit these services to the patient's dental plan for further consideration.	1. Verify patient eligibility before submitting a claim to the medical plan. 2. Coordinate with the dental plan provider if the rendered services are dental-related. 3. Stay updated with changes in the plan to avoid this denial.
CARC 271	It occurs when prior contractual reductions on a current payment schedule for deferred amounts were already reported. It is used with group code OA.	1. Review and update contractual agreements to avoid any discrepancies or deferred amounts. 2. Streamline your documentation process to track and report any deferred amounts or prior contractual reductions. 3. Conduct regular audits to identify any discrepancies related to prior contractual reductions.
CARC 272	It indicates that the healthcare provider's services did not meet the coverage or program guidelines.	1. Verify eligibility before providing any healthcare services. 2. Obtain prior authorization from the payer for certain procedures or treatments. 3. Ensure accurate documentation to support the medical necessity of the rendered services.
CARC 273	This denial is triggered when the healthcare provider exceeds the coverage or program guidelines.	1. Verify eligibility to prevent exceeding coverage or program guidelines. 2. Obtain prior authorization for certain procedures or treatments to avoid denials based on exceeding coverage or program guidelines. 3. Review the patient's medical records to ensure

		medical necessity.
CARC 274	It indicates that a healthcare provider's fee/service is not payable due to a patient care coordination arrangement.	1. Educate patient on insurance coverage limitations and services that may not be payable under their specific arrangement. 2. Verify insurance coverage to identify any potential limitations or exclusions related to care coordination arrangements. 3. Train staff on the specific requirements and limitations of different care coordination arrangements.
CARC 275	It occurs when the prior payer does not cover the patient's responsibility, like deductibles or co-payments. It is used with group code PR.	1. Verify insurance eligibility to identify coverage limitations or patient responsibilities that may not be covered by the prior payer. 2. Educate patients on their insurance coverage. 3. Collect patient payments upfront.
CARC 276	It means that the services rejected by the previous payer are not covered by the current payer.	1. Verify patient eligibility and coverage with the current payer. 2. Communicate with the prior payer and current payer where services are denied. 3. Stay current on specific policies and guidelines of each payer.
CARC 277	You may receive this denial code when a claim or service is not determined during the premium payment grace period.	1. Educate patients on premium payments and the consequences of non-payment. 2. Regularly verify eligibility to identify any potential issues with premium payments. 3. Ensure that premium payments are made on time to avoid any grace period issues.
CARC 278	It indicates that the performance program requirements are not met.	1. Train staff on the performance program proficiency requirements. 2. Regularly monitor staff performance to identify areas where proficiency requirements are met. 3. Regularly provide feedback and coaching to your staff.
CARC 279	It occurs when services are not provided by Preferred network providers, and there are limitations on using contracted providers outside of the member's network.	1. Verify network participation before providing services to a patient. 2. Train staff on network limitations. 3. Inform patients about their network limitations and the importance of using preferred network

		providers.
CARC 280	It identifies that the medical plan received the claim, but the benefits are not covered, and you need to submit the services to the patient's pharmacy plan for further consideration.	1. Verify eligibility for the specific medical plan before claim submission. 2. Understand medical plan coverage's limitations and exclusions. 3. Coordinate with the patient's pharmacy plan if the services provided are not covered under the patient's medical plan.
CARC 281	It means the deductible is waived as per the contractual agreement. It is used with group code CO.	1. Review the terms and conditions to confirm if the deductible is waived for specific services or procedures. 2. Communicate with payers to clarify any uncertainties regarding deductible waivers. 3. Train staff on changes in contractual agreements or payer policies.
CARC 282	You may receive this denial when the procedure or revenue code does not match the type of bill.	1. Ensure that the procedure/revenue code aligns with the type of bill. 2. Train staff on different types of bills and the corresponding procedure/revenue codes. 3. Utilize automated billing software that can flag discrepancies between the procedure/revenue code and the type of bill.
CARC 283	It means that the attending provider who is responsible for directing the patient's care is not eligible.	1. Ensure that the attending provider meets all eligibility requirements to provide direction of care. 2. Train staff and providers on the specific requirements and regulations related to their eligibility to provide direction of care.
CARC 284	It occurs when the recertification, authorization, notification, or pre-treatment number is valid but does not apply to the billed services.	1. Ensure accurate and timely precertification before providing any services. 2. Communicate with payers to clarify uncertainties regarding the precertification or authorization process. 3. Train staff on precertification requirements.
CARC 285	It identifies a situation where the appeal procedures were not followed correctly.	1. Establish clear appeal protocols to avoid this denial. 2. Identify claim denial and initiate the appeal process within the designated timeframe.

		3. Analyze the reasons behind denial and identify gaps in the initial claim submission.
CARC 286	It is triggered when the appeal time limits for a healthcare claim are not met.	1. Implement a robust appeals management process. 2. Identify denial reasons promptly and communicate to the appropriate staff members responsible for appeals. 3. Establish effective communication channels between the billing department, coding team, and clinical staff.
CARC 287	It means the referral for healthcare services has exceeded the allowed limit.	1. Communicate with referring providers to obtain all necessary documentation and authorizations. 2. Utilize electronic referral systems, standardized referral forms, and automated reminders to ensure timely completion of referrals. 3. Train staff on referral guidelines.
CARC 288	It occurs when a referral is missing or not provided, resulting in a claim denial.	1. Collect all necessary information from the referring provider, verifying the referral's validity. 2. Communicate with referring providers to ensure that all necessary referrals are received in a timely manner. 3. Train staff on referral requirements.
CARC 289	It indicates that the services are not covered by dental and medical plans, so benefits are unavailable.	1. Verify coverage eligibility for dental and medical plans before providing any services. 2. Obtain pre-authorization for services considered under both dental and medical plans. 3. Ensure accurate documentation supporting the medical necessity.
CARC 290	It indicates that the dental plan does not cover the benefits claimed and you should submit the claim to the patient's medical plan for review.	1. Verify eligibility to ensure the patient's dental plan covers the specific benefits. 2. Coordinate with the medical plan if the dental plan does not cover the claimed benefits. 3. Educate patients about their dental plan coverage and limitations.
CARC 291	It means the medical plan does not cover the benefits claimed. You should	1. Verify eligibility for the patient's medical plan before claim submission.

	submit it to the patient's dental plan for review.	2. Coordinate with the dental plan if the claim is related to dental services. 3. Review limitations and exclusions of the patient's medical plan.
CARC 292	It occurs when the medical plan does not cover the claimed benefits and you should submit it to the patient's pharmacy plan for review.	1. Verify eligibility for the patient's medical plan before claim submission. 2. Educate patients about their insurance coverage and its limitations or exclusions. 3. Coordinate benefits if the patient has multiple insurance plans.
CARC 293	It is triggered when the payment is made to the employer instead of the healthcare provider.	1. Ensure accurate and up-to-date employee information to prevent payments from being made to the employer. 2. Utilize automated payment systems to reduce the risk of payments being made to the employer. 3. Educate staff on how to prevent this denial.
CARC 294	It indicates that a payment is made directly to an attorney instead of the healthcare provider.	1. Ensure accurate documentation, including the purpose of the payment, the rendered services, and other material such as legal agreements or invoices. 2. Train staff on compliance regulations and guidelines related to attorney payments.
CARC 295	It is related to Pharmacy Direct/Indirect Remuneration (DIR). It indicates issues related to the reimbursement or remuneration for pharmacy services.	1. Perform routine audits of pharmacy DIR transactions to ensure accuracy and compliance with contractual agreements. 2. Collaborate with pharmacies to ensure all necessary documentation and information are provided accurately and timely. 3. Train staff on DIR requirements and documentation guidelines.
CARC 296	It identifies that the precertification, authorization, notification, or pre-treatment number is valid but does not apply to the provider.	1. Verify provider participation in the patient's insurance network before scheduling procedures or services. 2. Obtain preauthorization or precertification from the insurance company for specific procedures or services. 3. Communicate with the insurance company to clarify doubts or questions regarding

		preauthorization requirements.
CARC 297	It occurs when the medical plan receives the claim, but the benefits are not covered and you should submit the services to the patient's vision plan for further consideration.	1. Submit the services to the patient's vision plan for review. 2. Verify the patient's eligibility to determine if there are any specific requirements or limitations related to vision plans.
CARC 298	It is when the medical plan receives the claim, but the benefits are not covered under this plan, and the claim has been sent to the patient's vision plan for review.	1. Verify eligibility for the specific medical plan before claim submission. 2. Coordinate benefits in cases where the patient has multiple insurance plans. 3. Stay updated on changes in the medical plan's policies and coverage.
CARC 299	It means the billing provider cannot get paid for their billed service.	1. Verify provider eligibility for receiving payment for the billed service. 2. Ensure accurate documentation, including the provider's NPI (National Provider Identifier). 3. Stay updated with payer requirements for provider eligibility.
CARC 300	It indicates that the claim was received by the medical plan, but benefits are unavailable and have been forwarded to the patient's behavioral health plan for further review.	1. Verify the patient's eligibility for the specific medical plan before claim submission. 2. Understand different plan coverages and their limitations and exclusions. 3. Coordinate with the behavioral health plan if the patient's medical plan does not cover the specific services.
CARC 301	It means the claim was received by the medical plan, but the benefits are not covered and you should submit the services to the patient's behavioral health plan for further consideration.	1. Verify the patient's insurance coverage under the medical plan before claim submission. 2. Communicate with the patient's behavioral health plan in cases where the services are not covered under the patient's medical plan. 3. Stay updated with the medical plan's coverage guidelines.
CARC 302	It occurs when the time limit for obtaining pre-approval or authorization for a medical treatment has expired.	1. Obtain all necessary pre-certifications, notifications, authorizations, or pre-treatment time limits for scheduled procedures or services. 2. Utilize the EHR system with built-in alerts and

		reminders for pre-certification expiration dates. 3. Educate staff and patients on meeting pre-certification requirements and the potential consequences of missing deadlines.
CARC 303	You may receive this denial code when the prior payer does not cover the patient's responsibility (deductible, coinsurance, co-payment) for qualified Medicare and Medicaid beneficiaries.	1. Verify the patient's eligibility for Medicare and Medicaid benefits before providing services. 2. Educate patients on their financial responsibility, including deductibles, coinsurance, and co-payments. 3. Utilize RCM software to streamline the claims submission and follow-up process.
CARC 304	It occurs when the medical plan receives the claim, but the benefits are not covered and you should submit these services to the patient's hearing plan for further consideration.	1. Verify the patient's insurance coverage before claim submission. 2. Inform the patient of their insurance coverage and any potential limitations. 3. Stay updated with the coverage details of different plans.
CARC 305	It identifies that the medical plan received the claim, but the benefits are not covered under this plan, and the claim is then sent to the patient's hearing plan for further review.	1. Verify the patient's eligibility for the specific medical plan before claim submission. 2. Review the patient's medical plan, its benefits, and limitations. 3. Coordinate with the patient's hearing plan if the claim is forwarded to it.
CARC A0	It is related to a patient refund amount indicating the insurance claim submitted by the healthcare provider is denied because the patient owed a refund.	1. Ensure accurate documentation to prevent discrepancies or errors that may lead to a refund request. 2. Communicate with patients regarding their financial responsibilities. 3. Conduct regular internal audits to identify any potential coding or billing errors.
CARC A1	You may receive this denial code when a claim or service is denied because it lacks the necessary remark code, such as the NCPDP Reject Reason Code or the Remittance Advice Remark Code, as long as it is not an ALERT.	1. Verify that the claim includes at least one remark code, either an NCPDP Reject Reason Code or a Remittance Advice Remark Code, before submission. 2. Stay updated with coding guidelines, including changes or updates to claim adjustment reason codes.
CARC A5	It is related to Medicare claim PPS	1. Ensure accurate documentation, including

	capital cost outlier amount indicating it exceeds the predetermined outlier threshold for capital costs.	performed procedure details, information supporting medical necessity, test results, or consultation notes. 2. Stay updated with Medicare guidelines related to PPS capital cost outlier amount. 3. Establish effective communication channels between healthcare providers, coders, and billing staff.
CARC A6	It occurs when a patient's hospitalization or transfer does not meet the requirement of prior hospitalization or 30 days.	1. Ensure accurate documentation, including dates, facility names, and other relevant information. 2. Utilize an EHR system to access patient records and track and verify prior hospitalizations or transfers. 3. Train staff on the specific criteria for meeting the prior hospitalization or transfer requirement.
CARC A8	It is for an ungroupable DRG, which means the diagnosis-related group (DRG) code assigned to a patient's medical claim cannot be categorized properly.	1. Ensure accurate documentation, including assigning the appropriate DRG, to reduce the chances of an ungroupable DRG code. 2. Utilize medical billing software with built-in coding rules and edits to identify coding errors or inconsistencies. 3. Conduct regular internal coding audits to minimize the occurrence of ungroupable DRG codes.
CARC B1	It indicates that the visits or services provided are not covered by the patient's insurance plan.	1. Verify insurance coverage before scheduling appointments or providing services. 2. Obtain prior authorization to minimize the risk of denials for non-covered visits or services. 3. Educate patients about coverage limitations.
CARC B4	It is related to the late filing penalty that healthcare providers may encounter when submitting claims for reimbursement.	1. Ensure timely claim submission as per the payer's guidelines. 2. Maintain accurate and complete documentation for each patient encounter. 3. Utilize RCM software to streamline the claim submission process.
CARC B7	It means the provider was not certified/eligible to be paid for a specific procedure/service on a	1. Verify provider certification and eligibility for performing the specific procedure or service on the date of service.

	certain date.	2. Ensure accurate documentation, including the provider's certification or eligibility for the specific procedure or service. 3. Submit claims on time to avoid issues related to provider certification or eligibility.
CARC B8	This denial code identifies that alternative services were available and should have been used.	1. Ensure accurate documentation and demonstrate that alternative services were not available or appropriate for the patient's needs. 2. Utilize evidence-based guidelines to determine the most appropriate service for a patient. 3. Collaborate with insurance payer to understand their specific requirements and policies regarding service utilization.
CARC B9	It means the patient is enrolled in a hospice.	1. Verify patient eligibility for hospice care before rendering services. 2. Ensure accurate documentation, including the start and end dates of hospice care, and any changes in the patient's status or level of care. 3. Train staff on the guidelines and requirements for hospice care.
CARC B10	You may receive this denial code when the allowed amount is reduced because a part of the procedure/test was already paid.	1. Obtain pre-authorization from the payer before performing any procedure or test. 2. Verify patient eligibility to ensure the beneficiary is not liable for more than the allowed amount. 3. Ensure accurate documentation justifying the billed amount to avoid reductions in the allowed amount.
CARC B11	It is triggered when the claim or service has been sent to the correct payer/processor for processing, but it is not covered by that payer/processor.	1. Double-check the payer's name, address, and contact information to avoid any transfer issues. 2. Review payer guidelines to determine if the claim/service is eligible for reimbursement from that particular payer. 3. Ensure accurate documentation supporting the medical necessity.
CARC B12	It occurs when the services provided are not properly documented in the patient's medical records.	1. Ensure accurate documentation, including the service nature, the date and time it was provided, and any supporting information or findings.

		2. Train staff on proper documentation practices. 3. Utilize an EHR system to reduce the risk of missing or incomplete information.
CARC B13	You may receive this denial code when a claim or service has already been paid for in a previous payment.	1. Verify patient eligibility, including if the patient has any previous payments for the same claim or service. 2. Regularly review payment records to identify and rectify any potential issues before they result in this denial code. 3. Communicate with the payer to clarify any payment discrepancies.
CARC B14	It means only one visit or consultation per physician per day is covered.	1. Utilize a scheduling system to prevent multiple visits or consultations with the same physician on the same day. 2. Train staff on adhering to the policy of only one visit or consultation per physician per day. 3. Perform regular audits to identify instances where multiple visits or consultations with the same physician on the same day may have been billed incorrectly.
CARC B15	It indicates that a required service/procedure is missing or not covered.	1. Ensure accurate documentation, including any qualifying services or procedures required for coverage. 2. Communicate with the insurance payer to clarify coverage requirements or seek clarification on specific cases. 3. Train staff on verifying coverage requirements and effective communication with payers.
CARC B16	It occurs when a healthcare provider submits a claim for a new patient, but the patient's qualifications for being considered a new patient are not met.	1. Ensure accurate documentation, including previous encounters, treatments, and other information supporting the classification of the patient as a new patient. 2. Educate patients on providing accurate information regarding their medical history and previous encounters. 3. Train staff on patient registration and scheduling.
CARC B20	It identifies that the procedure or service was already provided by	1. Collaborate with other providers involved in the patient's care.

	another healthcare provider.	2. Verify insurance coverage to determine if any specific requirements or restrictions are in place. 3. Ensure accurate documentation, including the forms/bills from the provider responsible for each procedure or service rendered.
CARC B22	It indicates a payment adjustment based on the diagnosis.	1. Ensure accurate documentation, supporting the medical necessity of the services, and minimize the chances of a payment adjustment based on the diagnosis. 2. Stay updated on the specific policies and guidelines of the payers you work with.
CARC B23	It is triggered when the procedure billed is not authorized according to the Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	1. Ensure CLIA proficiency test compliance to confirm that the billed procedures are authorized. 2. Implement a robust authorization process for all laboratory procedures before they are performed. 3. Train staff on the specific requirements related to CLIA proficiency testing.
CARC P1	You may receive this denial when there is a state-mandated requirement for property and casualty claims.	1. Ensure accurate documentation, including the nature of the injury or property damage, the cause of the incident, and any other details required by the state. 2. Stay updated on state regulations for property and casualty claims. 3. Train staff on the specific requirements for property and casualty claims.
CARC P2	It identifies that the patient's injury or illness is not related to their work, and the Workers' Compensation carrier is not responsible for covering the costs associated with the treatment.	1. Ensure accurate documentation, including the circumstances surrounding the injury or illness, and any witness statements. 2. Verify Workers' Compensation coverage before providing services. 3. Train staff on Workers' Compensation guidelines.
CARC P3	It is triggered when a Workers' Compensation case has been settled and the patient is responsible for the claim/service cost through a specific	1. Verify Workers' Compensation coverage before providing any services. 2. Obtain necessary authorizations from the Workers' Compensation carrier before providing

	arrangement.	any services. 3. Educate patient about the limitations and exclusions of their coverage.
CARC P4	It occurs when a Workers' Compensation claim is deemed non-compensable and the payer is not responsible for the claim or service/treatment.	1. Verify the patient's eligibility and coverage under the Workers' Compensation insurance. 2. Understand jurisdictional regulations related to Workers' Compensation claims. 3. Stay updated with the policies and guidelines of the Workers' Compensation payer.
CARC P5	It indicates that the fees charged by a healthcare provider are not reasonable and customary and this code is specific to property and casualty claims.	1. Verify payer fee schedules to understand the reasonable and customary fees set by the payer for different services. 2. Stay updated with legislated fee arrangements that may impact your reimbursements. 3. Train staff on payer fee schedules and legislated fee arrangements.
CARC P6	It is related to entitlement to benefits, and providers should refer to the insurance policy number segment or healthcare policy identification segment for jurisdictional regulations. It is used for property and casualty only.	1. Verify patient eligibility before providing any healthcare services. 2. Ensure accurate documentation justifying the medical necessity of rendered services. 3. Stay updated with payer policies to avoid this denial.
CARC P7	You may receive this denial code when the billed code is not found in the fee schedule/fee database. It is used for property and casualty only.	1. Review fee schedules to ensure the billed code is included in the appropriate fee schedule or fee database. 2. Train staff on the latest coding guidelines and payer policies. 3. Conduct regular audits to identify any coding errors or discrepancies.
CARC P8	It means the claim is under investigation. It is used for property and casualty only.	1. Ensure accurate documentation, including patient demographics, medical history, and treatment details. 2. Verify insurance coverage before claim submission. 3. Submit error-free clean claims and comply with the payer requirements.
CARC P9	It is triggered when there is no	1. Ensure accurate and complete documentation

	appropriate code to describe a service. It is specifically for property and casualty cases.	to prevent confusion or ambiguity when submitting claims. 2. Train staff on specific codes required for property and casualty claims. 3. Collaborate with payers to clarify any coding requirements specific to property and casualty claims.
CARC P10	It occurs when payment is reduced to zero due to ongoing litigation, and more details will be provided after the litigation is resolved. It is only applicable to property and casualty cases.	1. Submit claims within the deadline to avoid payment reduction due to litigation. 2. Comply with legal and regulatory requirements to prevent payment reduction due to litigation. 3. Collaborate with payers to address any potential issues or concerns related to litigation.
CARC P11	It indicates that the status of an injury or illness claim is pending due to legal action. It is specific to property and casualty claims. It is used with group code OA.	1. Ensure accurate and complete documentation, including the nature of the injury or illness, ongoing litigation, and the related property and casualty claim status. 2. Collaborate with legal teams to stay updated on pending litigation related to the injury or illness. 3. Utilize an EHR system to streamline the claim submission process.
CARC P12	It is related to a Workers' Compensation jurisdictional fee schedule adjustment, indicating an adjustment to the claim or line level based on the fee schedule specific to Workers' Compensation cases.	1. Ensure accurate documentation, including injury type, treatment provided, and any other necessary details. 2. Verify Workers' Compensation jurisdictional fee schedules. 3. Stay updated on changes in Workers' Compensation regulations that may impact reimbursement.
CARC P13	You may receive this denial code when a payment is reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies.	1. Stay current on Workers' Compensation jurisdictional regulations. 2. Ensure accurate documentation, including injury, treatment provided, and any supporting information required by the jurisdictional regulations. 3. Verify patient eligibility for Workers' Compensation benefits.
CARC P14	It means the payment for this service	1. Ensure accurate documentation, including all

	is already included in another service performed on the same day. It is used for property and casualty claims only.	relevant details and linking them to the appropriate codes. 2. Verify medical necessity by conducting thorough patient assessments and obtaining any required pre-authorization or referrals. 3. Train staff on coding and billing guidelines.
CARC P15	It is specific to Workers' Compensation cases. It indicates that the provided medical treatment fails to comply with the Workers' Compensation medical treatment guidelines.	1. Verify Workers' Compensation coverage before providing any medical treatment to a patient. 2. Adhere to medical treatment guidelines outlined by the Workers' Compensation system in your state. 3. Document treatment necessity and rationale.
CARC P16	It means the medical provider is not authorized to treat injured workers in this area. It is used for Workers' Compensation claims.	1. Ensure proper authorization before providing treatment to injured workers. 2. Stay current on Workers' Compensation regulations in their jurisdiction. 3. Collaborate with the payer to prevent this denial code.
CARC P17	It occurs when a referral is not authorized by the attending physician as required by regulations. This code is specific to property and casualty cases.	1. Obtain the necessary authorization from the attending physician before referring a patient for any services. 2. Educate staff on regulatory requirements related to property and casualty cases. 3. Utilize a referral management system to streamline the process.
CARC P18	You may encounter this denial when a procedure is not listed in the fee schedule but an allowance is made for a similar service. This code is specific to property and casualty claims.	1. Ensure the procedure is listed in the jurisdiction fee schedule before performing it. 2. Communicate with payers in cases where a procedure is not listed in the fee schedule. 3. Ensure accurate documentation supporting the medical necessity and appropriateness of the procedure.
CARC P19	It means no payment is due for a procedure because it has a value of zero in the fee schedule. It is only used for property and casualty claims.	1. Verify insurance coverage before providing service. 2. Obtain prior authorization to ensure the procedure is medically necessary and eligible for reimbursement. 3. Stay updated with fee schedules provided by different insurance companies.

CARC P20	It indicates that the service is not paid according to the allowed outpatient facility fee schedule. It is specific to property and casualty cases.	1. Verify insurance coverage before providing any services. 2. Ensure accurate documentation, including evidence of the services being performed according to the patient's medical condition. 3. Conduct regular audits to identify errors leading to this denial.
CARC P21	It occurs when a payment is denied based on jurisdictional regulations or payment policies related to Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) benefits.	1. Stay updated on the regulations related to MPC and PIP benefits in your jurisdiction. 2. Verify the patient's insurance coverage and ensure that it includes MPC and PIP benefits. 3. Ensure accurate documentation justifying the need for payment under MPC and PIP benefits.
CARC P22	It means the payment is adjusted based on jurisdictional regulations or payment policies related to Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) benefits. It is specific to property and casualty auto claims.	1. Stay updated on the regulations related to MPC and PIP benefits in your jurisdiction. 2. Verify the patient's insurance coverage and determine if MPC and PIP benefits are applicable before providing services. 3. Communicate with payers to understand their specific requirements and policies related to MPC and PIP benefits.
CARC P23	It is related to Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) benefits jurisdictional fee schedule adjustment, indicating the adjustment made by the payer is based on the fee schedule determined by the jurisdiction. This code applies to property and casualty auto claims.	1. Ensure all documentation related to MPC or PIP benefits is accurate and complete. 2. Verify jurisdictional fee schedules for MPC or PIP benefits. 3. Review and reconcile transactions to identify any adjustments related to MPC or PIP benefits.
CARC P24	It indicates that a payment is adjusted based on a Preferred Provider Organization (PPO). It is used for property and casualty claims.	1. Maintain a comprehensive database of all contracts with PPOs to ensure that they align with the provided services. 2. Verify patient eligibility and benefits with the PPO before providing services. 3. Ensure accurate documentation to support the medical necessity and level of care provided.
CARC P25	You may receive this denial code when a payment is adjusted based on	1. Regularly update MPN information to avoid any discrepancies that may lead to payment

	the Medical Provider Network (MPN). It is specific to property and casualty claims.	adjustments. 2. Review contracts and agreements to understand the specific terms and conditions related to MPN adjustments. 3. Stay updated with regulatory changes related to MPN adjustments.
CARC P26	It identifies payment adjustments based on the Voluntary Provider Network (VPN). It is specific to property and casualty claims.	1. Ensure accurate network participation to prevent payment adjustments based on VPN. 2. Verify contract terms to understand the specific terms and conditions related to VPN adjustments. 3. Stay updated with regulatory requirements related to VPN adjustments.
CARC P27	It is a payment denial based on jurisdictional regulations and/or payment policies for liability coverage benefits.	1. Review and understand the jurisdictional regulations and payment policies related to liability coverage benefits. 2. Ensure accurate documentation of liability coverage information for each patient. 3. Conduct audits to identify any potential issues or discrepancies related to liability coverage benefits.
CARC P28	It occurs when a payment is adjusted based on the liability coverage benefits jurisdictional regulations and/or payment policies.	1. Ensure accurate and up-to-date liability coverage information to prevent this denial code. 2. Review and validate claim information before claim submission. 3. Communicate with payers in case of any doubts or uncertainties regarding jurisdictional regulations' application.
CARC P29	It is a fee schedule adjustment related to liability benefits. It can be at the claim or line level and requires the payer to send specific information to the provider.	1. Ensure accurate and up-to-date jurisdictional fee schedules to ensure they align with the current regulations and guidelines. 2. Utilize electronic data interchange (EDI) capabilities to electronically transmit claims and receive remittance advice from payers. 3. Stay informed about healthcare policies and regulations related to liability benefits.
CARC P30	You may receive this denial code when payment is denied for an	1. Ensure that all supporting documentation is complete and accurate before claim

	exacerbation due to incomplete supporting documentation.	submission. 2. Collaborate with the insurance company to address any documentation requirements or queries promptly.
CARC P31	It indicates that the payment is denied for an exacerbation when the treatment exceeds the allowed time.	1. Ensure accurate documentation, including start and end times of each session or treatment, and time spent on patient care beyond the standard allowance. 2. Use appropriate time-based codes when billing for services that exceed the standard time allowed. 3. Communicate with payers regarding treatment time allowances.
CARC P32	It occurs when a payment is adjusted because it needs to be divided among multiple parties.	1. Ensure accurate documentation to prevent any discrepancies that could lead to apportionment-related denials. 2. Collaborate with payers to clarify any questions or concerns regarding apportionment. 3. Submit claims on time, adhering to payer-specific deadlines.