CARC Validation Examples

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1. Introduction

MassHealth/SENDPro will be using active standard Claim Adjustment Reason Codes (CARCs) from X12 External Codes Source 139. The assumption is that all MCEs follow industry and X12 validation standards and produce appropriate denials from their respective adjudication systems. MassHealth expects MCEs to adhere to the following guidelines for populating CARCs.

Please note the following.

- SENDPro applies less stringent validation edits on denied claims/encounters in order to capture the necessary requirement(s) for reporting denials to CMS.
- These CARC requirements apply to all participating payers (primary, secondary, tertiary, etc.) regardless of who paid first.
- Per X12 837, a CARC is always required when a CAS segment is populated.
- MCEs must use the appropriate CARCs in CAS02, 05, 08, 11, 14, 17 at the claim and service line level, as applicable.

2. CARC Validations and Examples

Note: *The below are examples only and are not intended to be fully formed EDI messages. MCEs must populate all data as applicable including, but not limited to, CAS, MIA, MOA, 2330A Other Subscriber Name, 2330B Other Payer Name, and 2400 service line information.*

<u>CARC Validations and Examples</u>

1. **For 837 paid claims (2300 CN104 = P) in paid claims file**
    a. For original, interim, or adjusted claims (CLM05-03 = 1-5 or 7), CARCs are required when paid amount is not equal to billed amount; any valid X12 CARC is accepted
    b. CARCs submitted on voided claims (CLM05-03 = 8) should reflect the CARCs applied on the void claims in the MCE system
    c. All CARCs must be valid X12 CARCs
    d. CARCs are not required when billed amount is equal to paid amount
    e. 837 Example (key segments/loops of EDI message):

1000A NM109 = MCE submitter PIDSL
2300 CLM02 = Total Claim Charge Amount
2300 CLM05-03 = Claim Frequency Code (1-5, 7 accepted)
2300 CN104 = P
2320 CAS02,05,08,11,14,17 = CARC's (only required when paid amount does not equal billed amount)
2320B NM109 = MCE submitter PIDSL

2. **For 837 fully denied claims (2300 CN104 = D) in denied claims file**
    a. Unless both billed amount and paid amount is $0, fully denied claims are required to have at least one valid X12 CARC at the line level for the payer who is the submitter. In addition, MassHealth highly encourages MCEs to provide CARCs at the header level where applicable, while conforming to IG standards for amount balancing (note that paid amount must always be $0)
    b. All claims must have an adjudication disposition of original (i.e. no adjustments or voids)
    c. At least one line level CARC must be populated for the payer that is the submitter
    d. All populated CARCs must be valid X12 CARCs
    e. Fully denied 837I Example (key segments/loops of EDI message):
        1000A NM109 = MCE submitter PIDSL
        2300 CLM05-03 (Claim Frequency Code) must be 1-5
        2300 CN104 = D
        2320B NM109 = MCE submitter PIDSL
        2400 SV203 (Line Item Charge Amount)
        2430 SVD01 (Other Payer Primary Identifier)
        2430 SVD02 (Service Line Paid Amount)
        2430 CAS02,05,08,11,14,17 (CARC)

3. **For 837 partially denied claims (2300 CN104 = R) in partially denied claims file**
    a. At the header, all CARCs must be valid if populated
    b. CARCs are not required for voids but will be validated if populated
    c. For 837P and D at the line level
        i. Note that 2400 CN104 is required for all lines and should always be 'P' or 'D' as applicable
        ii. For 837P and 837D, denied lines of partially denied claims are required to have at least one valid X12 CARC at the line level
        iii. For paid lines:
            1. All populated CARC(s) must be valid X12 CARCs
            2. CARCs are not required when billed amount is equal to paid amount
        iv. For denied lines:
            1. Unless both billed amount and paid amount is $0, at least one line level CARC must be populated for the payer that is the submitter
            2. All populated CARC(s) must be valid X12 CARC(s)
    d. 837P & 837D Example (key segments/loops of EDI message):

1000A NM109 = MCE submitter PIDSL
2300 CLM05-03 (Claim Frequency Code) (1-5, 7 accepted)
2300 CN104 = R
2320B NM109 = MCE submitter PIDSL
2400 CN104 = P or D
2400 SV203 (Line Item Charge Amount)
2430 SVD01
2430 CAS02,05,08,11,14,17 (CARC)

e. For 837I at the line level
   i. For 837I, denied lines of partially denied claims are required to have a CAS segment at the line level as per MassHealth CARC designation in the "Denied & Adjusted CARCs" tab
      1. If first CARC is “denied” for the payer that is the submitter, then line is validated as denied and all populated CARCs must be valid X12 CARCs
      2. 837I Partially Denied Example with Denied Line
      1000A NM109 = MCE submitter PIDSL
      2300 CLM02 (Total Claim Charge Amount)
      2300 CLM05-03 (Claim Frequency Code)
      2300 CN104 = R
      2320B NM109 = MCE submitter PIDSL
      2400 SV203 (Line Item Charge Amount)
      2430 SVD01
      2430 CAS02,05,08,11,14,17 (Denied CARC)

   ii. For 837I, adjusted lines of partially denied claims are required to have a CAS segment at the line level as per MassHealth CARC designation in the "Denied & Adjusted CARCs" tab
      1. Else no CAS or other CARC used for the payer that is the submitter, line is validated as paid and any populated CARCs must be valid X12 CARCs
      2. 837I Partially Denied Example with Paid Line
      1000A NM109 = MCE submitter PIDSL
      2300 CLM02 (Total Claim Charge Amount)
      2300 CLM05-03 (Claim Frequency Code)
      2300 CN104 = R
      2320B NM109 = MCE submitter PIDSL
      2400 SV203 (Line Item Charge Amount)
      2430 SVD01
      [no 2430 CAS (No Adjustments)]

or 2430 CAS02,05,08,11,14,17 (Adjustment CARC)

4. For 837I partially denied, if line billed amount is $0 for the payer who is the submitter (meaning CAS cannot be populated) then SENDPro will initially validate the line as denied applying minimal validations. Then, EDME will consider the line as either paid or denied under the following conditions:
    a. The line is considered paid under the following conditions:
        i. Bundled Services - Some procedures are bundled into a primary service and not separately reimbursed. The $0 line indicates the service was performed but is not billable on its own.
        ii. Capitated Payment - Arrangements in capitated contracts, providers receive a fixed amount per patient regardless of services rendered. Individual service lines may show $0 to reflect that no additional payment is expected.
        iii. Reporting Non-Covered Services - A provider may report a service that's not covered by the payer to document it was performed, even though no payment is expected.

    b. Otherwise, the line is considered denied even in the following situations because there is no means for EDME to assess whether the claim was actually paid or denied:
        i. Informational or Tracking Purposes - A service line may be included to document a procedure or diagnosis that doesn't require reimbursement but is relevant for clinical or administrative tracking.
        ii. Claim Reconciliation or Coordination of Benefits (COB) - A $0 line might be used to show that another payer has covered the service, and no additional billing is required from the current payer.

3. Denied & Adjusted CARCs

Please refer to attached document for full list of denied and adjusted CARCs. For 837I Partially Denied claims, the first CARC populated by the payor who is the MCE should align to the designations below, such that paid lines are aligned with adjustment codes and denied lines with denial codes. See above CARC Validations and Examples 3.e for details.

Code	Description	Adjustment/ Denied Categorization
1	Deductible Amount	Adjustment Code
2	Coinsurance Amount	Adjustment Code
3	Co-payment Amount	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code

Code	Description	Adjustment/ Denied Categorization
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
13	The date of death precedes the date of service.	Denial Code
14	The date of birth follows the date of service.	Denial Code
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	Denial Code
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	Denial Code
20	This injury/illness is covered by the liability carrier.	Denial Code
21	This injury/illness is the liability of the no-fault carrier.	Denial Code
22	This care may be covered by another payer per coordination of benefits.	Denial Code
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	Adjustment Code
24	Charges are covered under a capitation agreement/managed care plan.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
26	Expenses incurred prior to coverage.	Denial Code
27	Expenses incurred after coverage terminated.	Denial Code
29	The time limit for filing has expired.	Denial Code
31	Patient cannot be identified as our insured.	Denial Code
32	Our records indicate the patient is not an eligible dependent.	Denial Code
33	Insured has no dependent coverage.	Denial Code
34	Insured has no coverage for newborns.	Denial Code
35	Lifetime benefit maximum has been reached.	Denial Code
39	Services denied at the time authorization/pre-certification was requested.	Denial Code
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
44	Prompt-pay discount.	Adjustment Code
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	Adjustment Code
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code

Code	Description	Adjustment/ Denied Categorization
51	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
53	Services by an immediate relative or a member of the same household are not covered.	Denial Code
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Adjustment Code
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	Denial Code
61	Adjusted for failure to obtain second surgical opinion	Adjustment Code
66	Blood Deductible.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
69	Day outlier amount.	Adjustment Code
70	Cost outlier - Adjustment to compensate for additional costs.	Adjustment Code
74	Indirect Medical Education Adjustment.	Adjustment Code
75	Direct Medical Education Adjustment.	Adjustment Code
76	Disproportionate Share Adjustment.	Adjustment Code
78	Non-Covered days/Room charge adjustment.	Denial Code
85	Patient Interest Adjustment (Use Only Group code PR)	Adjustment Code
89	Professional fees removed from charges.	Adjustment Code
90	Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.	Adjustment Code
91	Dispensing fee adjustment.	Adjustment Code
94	Processed in Excess of charges.	Adjustment Code
95	Plan procedures not followed.	Denial Code
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Adjustment Code
100	Payment made to patient/insured/responsible party.	Adjustment Code
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	Adjustment Code
102	Major Medical Adjustment.	Adjustment Code
103	Provider promotional discount (e.g., Senior citizen discount).	Adjustment Code
104	Managed care withholding.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
105	Tax withholding.	Adjustment Code
106	Patient payment option/election not in effect.	Adjustment Code
107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	Denial Code
110	Billing date predates service date.	Denial Code
111	Not covered unless the provider accepts assignment.	Denial Code
112	Service not furnished directly to the patient and/or not documented.	Denial Code
114	Procedure/product not approved by the Food and Drug Administration.	Denial Code
115	Procedure postponed, canceled, or delayed.	Denial Code
116	The advance indemnification notice signed by the patient did not comply with requirements.	Denial Code
117	Transportation is only covered to the closest facility that can provide the necessary care.	Denial Code
118	ESRD network support adjustment.	Adjustment Code
119	Benefit maximum for this time period or occurrence has been reached.	Denial Code - Submit only if all the units are over the limit
121	Indemnification adjustment - compensation for outstanding member responsibility.	Adjustment Code
122	Psychiatric reduction.	Adjustment Code
128	Newborn's services are covered in the mother's Allowance.	Denial Code

Code	Description	Adjustment/ Denied Categorization
129	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Denial Code
130	Claim submission fee.	Adjustment Code
131	Claim specific negotiated discount.	Adjustment Code
132	Prearranged demonstration project adjustment.	Adjustment Code
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N/A - Pended claims in your system should not be submitted to MassHealth. If MCEs submit an encounter with this CARC, it will be rejected
134	Technical fees removed from charges.	Adjustment Code
135	Interim bills cannot be processed.	Denial Code
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	Denial Code
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	Adjustment Code
139	Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	N/A - Should not be used. If MCEs submit an encounter with this CARC, it will be rejected
140	Patient/Insured health identification number and name do not match.	Denial Code
142	Monthly Medicaid patient liability amount.	Adjustment Code
143	Portion of payment deferred.	Adjustment Code
144	Incentive adjustment, e.g. preferred product/service.	Adjustment Code
146	Diagnosis was invalid for the date(s) of service reported.	Denial Code
147	Provider contracted/negotiated rate expired or not on file.	Denial Code

Code	Description	Adjustment/ Denied Categorization
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Denial Code
149	Lifetime benefit maximum has been reached for this service/benefit category.	Denial Code
150	Payer deems the information submitted does not support this level of service.	Denial Code
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	Adjustment Code
152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
153	Payer deems the information submitted does not support this dosage.	Denial Code
154	Payer deems the information submitted does not support this day's supply.	Denial Code
155	Patient refused the service/procedure.	Denial Code
157	Service/procedure was provided as a result of an act of war.	N/A - Should not be used. If MCEs submit an encounter with this CARC, it will be rejected
158	Service/procedure was provided outside of the United States.	N/A - Should not be used. If MCEs submit an encounter with this CARC, it will be rejected
159	Service/procedure was provided as a result of terrorism.	N/A - Should not be used. If MCEs submit an encounter with this CARC, it will be rejected
160	Injury/illness was the result of an activity that is a benefit exclusion.	Denial Code
161	Provider performance bonus	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
163	Attachment/other documentation referenced on the claim was not received.	Denial Code
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	Denial Code
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	Denial Code
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
169	Alternate benefit has been provided.	Adjustment Code
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
172	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Adjustment Code
173	Service/equipment was not prescribed by a physician.	Denial Code
174	Service was not prescribed prior to delivery.	Denial Code
175	Prescription is incomplete.	Denial Code
176	Prescription is not current.	Denial Code
177	Patient has not met the required eligibility requirements.	Denial Code
178	Patient has not met the required spend down requirements.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
180	Patient has not met the required residency requirements.	Denial Code
181	Procedure code was invalid on the date of service.	Denial Code
182	Procedure modifier was invalid on the date of service.	Denial Code
183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
186	Level of care change adjustment.	Adjustment Code
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	Adjustment Code
188	This product/procedure is only covered when used according to FDA recommendations.	Denial Code
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	Denial Code
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
192	Non standard adjustment code from paper remittance. Usage: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	Adjustment Code
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	Denial Code
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	Denial Code
195	Refund issued to an erroneous priority payer for this claim/service.	Denial Code
197	Precertification/authorization/notification/pre-treatment absent.	Denial Code
198	Precertification/notification/authorization/pre-treatment exceeded.	Denial Code
199	Revenue code and Procedure code do not match.	Denial Code
200	Expenses incurred during lapse in coverage	Denial Code
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Adjustment Code
202	Non-covered personal comfort or convenience services.	Denial Code
203	Discontinued or reduced service.	Denial Code
204	This service/equipment/drug is not covered under the patient's current benefit plan	Denial Code
205	Pharmacy discount card processing fee	Adjustment Code
206	National Provider Identifier - missing.	Denial Code
207	National Provider identifier - Invalid format	Denial Code
208	National Provider Identifier - Not matched.	Denial Code

Code	Description	Adjustment/ Denied Categorization
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	Denial Code
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Adjustment Code
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Denial Code
212	Administrative surcharges are not covered	Denial Code
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	Denial Code
215	Based on subrogation of a third party settlement	Adjustment Code
216	Based on the findings of a review organization	N/A - other CARCs should be utilized to indicate the reason for adjustment or denial after review.
219	Based on extent of injury. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	Adjustment Code
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Adjustment Code
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	Denial Code
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)	Adjustment Code
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Denial Code
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Denial Code
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	Denial Code
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Usage: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	Denial Code
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code

Code	Description	Adjustment/ Denied Categorization
232	Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	Adjustment Code
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	Denial Code
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Denial Code
235	Sales Tax	Adjustment Code
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	Denial Code
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Adjustment Code
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	Adjustment Code
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	Denial Code
240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
241	Low Income Subsidy (LIS) Co-payment Amount	Adjustment Code
242	Services not provided by network/primary care providers.	Denial Code
243	Services not authorized by network/primary care providers.	Denial Code

Code	Description	Adjustment/ Denied Categorization
245	Provider performance program withhold.	Adjustment Code
246	This non-payable code is for required reporting only.	Denial Code
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	Adjustment Code
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	Adjustment Code
249	This claim has been identified as a readmission. (Use only with Group Code CO)	Denial Code
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	Denial Code
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	Denial Code
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	Denial Code
253	Sequestration - reduction in federal payment	Adjustment Code
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	Denial Code
256	Service not payable per managed care contract.	Denial Code

Code	Description	Adjustment/ Denied Categorization
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)	Denial Code
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	Denial Code
259	Additional payment for Dental/Vision service utilization.	Adjustment Code
260	Processed under Medicaid ACA Enhanced Fee Schedule	Adjustment Code
261	The procedure or service is inconsistent with the patient's history.	Denial Code
262	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only.	Adjustment Code
263	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only.	Adjustment Code
264	Adjustment for postage cost. Usage: To be used for pharmaceuticals only.	Adjustment Code
265	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.	Adjustment Code
266	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.	Adjustment Code
267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Denial Code

Code	Description	Adjustment/ Denied Categorization
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	Denial Code
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	Denial Code
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with Group Code OA)	Adjustment Code
272	Coverage/program guidelines were not met.	Denial Code
273	Coverage/program guidelines were exceeded.	Adjustment Code
274	Fee/Service not payable per patient Care Coordination arrangement.	Denial Code
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	Denial Code
276	Services denied by the prior payer(s) are not covered by this payer.	Denial Code
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)	Denial Code
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code

Code	Description	Adjustment/ Denied Categorization
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.	Denial Code
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.	Denial Code
281	Deductible waived per contractual agreement. Use only with Group Code CO.	Adjustment Code
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
283	Attending provider is not eligible to provide direction of care.	Denial Code
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	Denial Code
285	Appeal procedures not followed	Denial Code
286	Appeal time limits not met	Denial Code
287	Referral exceeded	Denial Code
288	Referral absent	Denial Code
289	Services considered under the dental and medical plans, benefits not available.	Denial Code
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.	Denial Code
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.	Denial Code
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.	Denial Code
293	Payment made to employer.	Adjustment Code
294	Payment made to attorney.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
295	Pharmacy Direct/Indirect Remuneration (DIR)	Adjustment Code
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	Denial Code
297	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's vision plan for further consideration.	Denial Code
298	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's vision plan for further consideration.	Denial Code
299	The billing provider is not eligible to receive payment for the service billed.	Denial Code
300	Claim received by the Medical Plan, but benefits not available under this plan. Claim has been forwarded to the patient's Behavioral Health Plan for further consideration.	Denial Code
301	Claim received by the Medical Plan, but benefits not available under this plan. Submit these services to the patient's Behavioral Health Plan for further consideration.	Denial Code
302	Precertification/notification/authorization/pre-treatment time limit has expired.	Denial Code
303	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered for Qualified Medicare and Medicaid Beneficiaries. (Use only with Group Code CO)	Denial Code
304	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's hearing plan for further consideration.	Denial Code
305	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's hearing plan for further consideration.	Denial Code
306	Type of bill is inconsistent with the patient status. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code

Code	Description	Adjustment/ Denied Categorization
307	Medicare Maximum Fair Price Standard Default Refund Amount Adjustment. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: To be used only for the Medicare Drug Price Negotiation Program.	Adjustment Code
308	Payment is adjusted due to contracted funding agreement between the payer and provider.	Adjustment Code
A0	Patient refund amount.	Adjustment Code
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) The following will be added to this definition on 7/1/2023, Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.	Denial Code
A5	Medicare Claim PPS Capital Cost Outlier Amount.	Adjustment Code
A6	Prior hospitalization or 30 day transfer requirement not met.	Denial Code
A8	Ungroupable DRG.	Denial Code
B1	Non-covered visits.	Denial Code
B4	Late filing penalty.	Adjustment Code
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
B8	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
B9	Patient is enrolled in a Hospice.	Denial Code
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	Denial Code
B12	Services not documented in patient's medical records.	Denial Code
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	Denial Code
B14	Only one visit or consultation per physician per day is covered.	Denial Code
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Denial Code
B16	'New Patient' qualifications were not met.	Denial Code
B20	Procedure/service was partially or fully furnished by another provider.	Denial Code
B22	This payment is adjusted based on the diagnosis.	Adjustment Code
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	Denial Code
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	Denial Code
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)	Adjustment Code
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	Denial Code
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	Denial Code
P6	Based on entitlement to benefits. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	Adjustment Code
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	Denial Code

Code	Description	Adjustment/ Denied Categorization
P8	Claim is under investigation. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	Adjustment Code
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	Denial Code
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	Adjustment Code
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	N/A - Pended claims in your system should not be submitted to MassHealth. If MCEs submit an encounter with this CARC, it will be rejected
P12	Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	N/A - Please reference other workers' compensation CARCs
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	Denial Code
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	Adjustment Code
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	Denial Code
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	Denial Code
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	Denial Code
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	Denial Code

Code	Description	Adjustment/ Denied Categorization
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	Denial Code
P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	Denial Code
P22	Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	Adjustment Code
P24	Payment adjusted based on Preferred Provider Organization (PPO). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty only. Use only with Group Code CO.	Adjustment Code
P25	Payment adjusted based on Medical Provider Network (MPN). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty only. (Use only with Group Code CO).	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
P26	Payment adjusted based on Voluntary Provider Network (VPN). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty only. (Use only with Group Code CO).	Adjustment Code
P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	Denial Code
P28	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	Adjustment Code

Code	Description	Adjustment/ Denied Categorization
P29	Liability Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	Adjustment Code
P30	Payment denied for exacerbation when supporting documentation was not complete. To be used for Property and Casualty only.	Denial Code
P31	Payment denied for exacerbation when treatment exceeds time allowed. To be used for Property and Casualty only.	Denial Code
P32	Payment adjusted due to Apportionment.	Adjustment Code