# CARC Code Memo

## 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.

### **Paid claims (2300 CN104 = P) in paid claims file**

* For original or adjusted claims (CLM05-03 = 1-5 or 7), CARCs are required when the paid amount is not equal to the billed amount; any valid X12 CARC is accepted.
* CARCs submitted on voided claims (CLM05-03 = 8) should reflect the CARCs applied on the void claims in the MCE system. MassHealth expects that all data elements (including amounts) on the voided encounter should match those submitted on the original (prior) claim.

### **Denied claims (2300 CN104 = D) in denied claims file**

Denied claims are required to have at least one valid X12 CARC at the line level. 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 the paid amount must always be $0).

### **Partially denied claims (2300 CN104 = R) in denied claims file**

* For 837P and D, denied lines of partially denied claims are required to have at least one valid X12 CARC at the line level.
* For 837I, denied lines of partially denied claims are required to have a CAS segment where all submitted X12 CARCs are a valid "denial code" at the line level, as per MassHealth CARC designation, in the "Denied & Adjusted CARCs" tab.
* For 837I, paid lines of partially denied claims are required to have a CAS segment where all submitted X12 CARCs are a valid "adjustment code" at the line level, as per MassHealth CARC designation, in the "Denied & Adjusted CARCs" tab.

**Please also note the following.**

* SENDPro applies less stringent validation edits on denied claims/encounters in order to capture the necessary requirement for reporting denials to CMS.
* These CARC requirements apply to all participating payers (primary, secondary, tertiary, etc.) regardless of who paid first.
* 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.

If you have any questions regarding this memo, please contact Augustus Matekole (augustus.matekole@mass.gov), Corey Chan (Corey.E.Chan@mass.gov), and Lauren Fecko (lfecko@deloitte.com).

## Denied & Adjusted CARCs

| **Code** | **Description** | **Adjustment/ Denied Categorization** |
| --- | --- | --- |
| 1 | Deductible Amount | Adjustment Code |
| 2 | Coinsurance Amount | Adjustment Code |
| 3 | Co-payment Amount | Adjustment Code |
| 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 |
| 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 |
| 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 |
| 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 |
| 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. | Denial 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |