

What Are CARC and RARC Codes?

When a health insurance company processes a medical claim, they send back a document called an **Explanation of Benefits (EOB)** or an **Electronic Remittance Advice (ERA)**. Inside this document, you will find special codes that tell you **why** the claim was paid a certain way, reduced, or denied. These codes fall into two groups:

CARC (Claim Adjustment Reason Code) — Tells you the *reason* the payment was adjusted or denied. Think of it as the 'why'.

RARC (Remittance Advice Remark Code) — Gives you extra *detail or instructions* about the adjustment. Think of it as the 'what to do next'.

Why Do These Codes Matter?

Every dollar that is adjusted or denied has a code attached. If your billing team knows how to read these codes quickly, they can correct and resubmit claims faster, appeal denials correctly, and ultimately collect more money for the practice. Ignoring these codes = lost revenue.

CARC Codes — The Most Common Ones

CAR C	Plain English Meaning	Most Common Cause	What To Do
1	Deductible amount not yet met	Patient has not paid their yearly deductible to the insurance plan	Bill the patient for this amount. Do NOT rebill insurance.
2	Coinsurance amount due from patient	Patient owes their share (e.g. 20%) after insurance pays its part	Bill the patient for the coinsurance amount shown.
3	Co-pay required	Patient owes a fixed visit fee (e.g. \$25 per visit)	Collect from patient at check-in or bill them.
4	Service is covered by another payer	Patient has more than one insurance plan (coordination of benefits)	Bill the other (secondary) insurance first, then come back.
5	Procedure not covered by this plan	The service is simply not in the patient's insurance benefits	Check the plan. May need prior auth or to bill patient.
6	Duplicate claim submitted	Same claim was sent twice	Do not resubmit. Trace the original claim first.
7	Claim filed after deadline	Claim was submitted too late	Submit timely next time. Appeal if you have a valid reason.
8	Claim/service has been paid to patient	Insurance paid the patient instead of the provider	Contact patient to collect payment made to them.
9	Patient and insured are not the same	Member info does not match records	Verify patient eligibility and correct ID info, resubmit.

CAR C	Plain English Meaning	Most Common Cause	What To Do
10	Diagnosis does not justify service	Medical necessity issue — diagnosis does not support the procedure billed	Review clinical notes. Change diagnosis or add more detail.
11	Service not covered — experimental	Treatment is considered experimental or not yet FDA approved	Provide supporting clinical literature. Appeal with evidence.
16	Claim/service lacks information	Missing or incorrect data on claim (NPI, diagnosis, modifiers, etc.)	Identify missing field, correct it, and resubmit promptly.
18	Exact duplicate of a prior claim	Identical claim already on file	Do not resubmit. Call insurance to check prior claim status.
19	Claim denied — workers compensation	Injury is related to work, so a different payer is responsible	Bill the workers comp carrier instead of health insurance.
22	Payment based on a lower allowed fee	Insurance paid at their contracted or reduced rate, not billed amount	If contracted, accept. If not, review contract terms.
23	Payment adjusted due to prior payment	Insurance already made a prior payment on this claim	Reconcile — check if overpayment or correct partial payment.
24	Charges not covered — HMO member out of network	Patient went outside their HMO network without authorization	Check if referral/auth was needed. Advise patient.
26	Expenses incurred before coverage began	Date of service is before the patient's plan start date	Verify the exact effective date of coverage. Bill patient.
27	Expenses after coverage ended	Date of service is after the patient's plan termination date	Verify coverage end date. Bill patient directly.
29	Claim timely filing limit exceeded	Claim was submitted past the insurer's deadline (e.g. 90 or 365 days)	Submit on time in future. Appeal with proof of timely filing.
45	Charge exceeds fee schedule	Billed amount is above what the insurance allows for this service	Accept contracted rate. No action usually needed.
50	Non-covered service by this payer/plan	Insurance plan does not cover this specific service at all	Bill patient or find alternate coverage. Check plan benefits.
51	Primary payer paid in full	Secondary claim — primary already paid 100% so secondary owes nothing	No further billing needed. Document as zero balance.
96	Non-covered charge(s)	Services are excluded from the patient's benefit plan	Review policy exclusions. Bill patient if applicable.
97	Benefit included in primary service paid	A separate code was billed but it is already included in another code	Check bundling rules. Remove unbundled code and resubmit.

CAR C	Plain English Meaning	Most Common Cause	What To Do
109	Claim not covered — referring/ordering provider	Referring provider is not valid, not credentialed, or not listed	Verify the referring provider's NPI and credentials. Correct.
119	Benefit maximum has been reached	Patient has hit their annual or lifetime limit for this service	Notify patient. No further billing to insurance this period.
131	Claim denied — specialty mismatch	Service was provided by wrong specialty for the diagnosis billed	Ensure provider specialty matches the service provided.
197	Precertification / authorization missing	Prior authorization was required but not obtained before service	Submit retro auth request. Appeal with clinical documentation.
200	Expenses incurred during a lapse in coverage	Patient's insurance lapsed at time of service	Bill patient. Verify future coverage before appointments.
243	Services not authorized by network	HMO/managed care plan did not approve the specific provider	Confirm network participation. Get auth before scheduling.

★ **PRO TIP:** Always read the CARC code first. It tells you the **ROOT CAUSE** of the denial or adjustment. Once you know the root cause, you know exactly where to start fixing the problem.

RARC Codes — Common Remark Codes Explained

RARC codes add more detail to the CARC code. You will almost always see them together on the remittance advice. RARC codes either give you more information (called 'informational') or tell you what action to take ('alert' codes, which start with the letter M, N, or MA).

RARC	Type	Plain English Meaning	Action Required
M1	Alert	Prior authorization or referral was not obtained for this service	Get auth before service next time. Appeal retro if possible.
M15	Info	Separately billed services are not payable with this procedure	Review NCCI edits. Remove unbundled code from claim.
M16	Alert	Alert — Please see the information provided in the ERA remarks	Read full ERA remark text carefully before taking action.
M20	Info	Service not payable — performed at this type of facility	Confirm the correct place of service code. Correct and resubmit.
M25	Alert	Missing/incomplete/invalid info for the rendering provider	Add or correct NPI, taxonomy, or name of rendering provider.
M27	Alert	Alert — Missing consent for release of information	Attach signed patient release form and resubmit claim.
M36	Info	This is a malpractice claim — bill appropriate carrier	Submit to the correct malpractice insurance, not health plan.
M44	Alert	Missing/incomplete/invalid condition codes	Check and add the correct condition code to the claim form.
M47	Alert	Missing/incomplete/invalid claim number on the claim	Include the original claim number when resubmitting or appealing.
M49	Alert	Missing/incomplete/invalid billing NPI	Enter the correct billing provider NPI on the claim.
M50	Alert	Missing/incomplete/invalid rendering NPI	Enter the correct rendering provider NPI on the claim.
M51	Alert	Missing/incomplete/invalid procedure code(s)	Verify and correct the CPT/HCPCS code. Resubmit.
M52	Alert	Missing/incomplete/invalid diagnosis code(s)	Correct the ICD-10 diagnosis code. Ensure it supports the service.
M53	Alert	Missing/incomplete/invalid date of service	Enter the exact date the service was provided. Resubmit.
M55	Alert	Missing/incomplete/invalid total charges	Verify total billed amount. Correct and resubmit.
M56	Alert	Missing/incomplete/invalid payer name and ID	Enter the correct insurance name and payer ID. Resubmit.
M65	Info	Patient is not liable for more than the charge amount	Do not bill patient more than what was originally billed.

RARC	Type	Plain English Meaning	Action Required
M76	Info	Missing/incomplete/invalid prescribing provider information	Add prescribing provider name, NPI, and DEA if applicable.
M79	Alert	Missing/incomplete/invalid purchase price	Required for DME claims — add the purchase price of equipment.
M80	Alert	Not covered if provided more than once in same period	Check frequency limits. Do not rebill same service this period.
M86	Alert	Service denied because payment received from another payer	Confirm coordination of benefits. Review other payer payment.
MA01	Alert	If you don't agree, you may appeal this determination	File a formal appeal within the deadline shown on the ERA.
MA02	Info	This claim has been approved for payment	No action needed. Verify deposit matches ERA.
MA04	Info	Secondary payment cannot be made without primary info	Submit primary EOB with the secondary claim. Resubmit.
MA07	Alert	Claim filtered — not processed in this cycle	Resubmit claim. It was not worked during this payment run.
MA08	Alert	Missing/incomplete/invalid primary payer details	Attach primary insurance payment info and resubmit to secondary.
MA15	Info	Unable to process more than 5 procedures per claim	Split the claim. Submit multiple claims with max 5 lines each.
MA18	Alert	Claim sent to different payer for payment	Resubmit to the payer listed. Wrong insurance was billed.
MA25	Alert	Missing/incomplete/invalid assistant surgeon information	Add the assistant surgeon's NPI and credentials. Resubmit.
MA36	Alert	Missing/incomplete/invalid patient's date of birth	Verify and enter the patient's correct date of birth.
MA61	Alert	Missing/incomplete/invalid social security number	Enter patient's SSN if required by payer. Resubmit.
N1	Alert	Alert: Please refer to your contract for this adjustment	Review your provider contract. The adjustment is per contract terms.
N4	Info	Missing/incomplete/invalid present on admission indicator	For inpatient claims, add the POA indicator for each diagnosis.
N19	Info	Claim denied — service not covered under this plan	Verify plan benefits. Bill patient if service is non-covered.
N20	Info	Service not payable with another service on this date	Check NCCI edits. Remove the conflicting code or add modifier.
N29	Alert	Missing/incomplete/invalid admission date	Enter the exact inpatient admission date. Resubmit.
N30	Alert	Patient / insured health ID or name does not match	Verify member ID and name spelling against insurance card.

RARC	Type	Plain English Meaning	Action Required
N58	Alert	Missing/incomplete/invalid other carrier data	Include all other payer information if patient has multiple plans.
N104	Alert	Service inconsistent with patient's age	Check age-related billing rules. Verify correct patient info.
N115	Info	This decision was based on clinical documentation	Clinical review was used. Gather records to support appeal.
N130	Alert	Consult plan benefit documents for covered services	Review the patient's plan booklet to understand covered services.
N290	Alert	Missing/incomplete/invalid rendering provider taxonomy code	Add the correct taxonomy code for the rendering provider.
N362	Alert	SNF stay not covered without a qualifying hospital stay	Confirm the patient had a qualifying 3-night inpatient hospital stay.
N517	Alert	Resubmit with supporting clinical documentation	Attach clinical notes, labs, or imaging reports and resubmit.
N543	Alert	Denial based on clinical review criteria	Medical necessity was denied. Appeal with detailed clinical evidence.
N570	Alert	Missing/incomplete/invalid place of service	Verify and enter the correct 2-digit place of service code.
N572	Alert	Missing/incomplete/invalid type of bill	For institutional claims, check and correct the 3-digit type of bill.

★ **REMEMBER:** Alert RARC codes (M, MA, N codes) require you to take action. Informational RARC codes are just explaining the adjustment. Focus your energy on the Alert codes first!

Quick Action Guide — What To Do When You See These Codes

Situation	CARC / RARC	Action in Plain English
Claim denied — missing information	16 / M25, M49, M50, M51, M52	Find the missing field from the ERA. Correct it in your billing software and resubmit within 30 days.
Claim denied — timely filing	29	Check your records for proof of original submission (clearinghouse report). Appeal with proof attached.
Claim denied — no authorization	197 / M1	Contact the insurance to request a retroactive authorization. Attach clinical notes. Do not ignore this.
Patient deductible not met	1	Transfer balance to patient responsibility in your system. Send patient a statement. Do not rebill insurance.
Claim paid at reduced rate	45	If you are contracted, accept the rate. If not contracted, review the EOB and contact the payer.
Duplicate claim denial	6 / 18	Do NOT resubmit again. Call the payer to check status of the original. Only appeal if original was not paid.
Coordination of benefits issue	4 / N58	Collect the primary EOB. Attach it and submit to the secondary insurance within timely filing limits.
Service not medically necessary	10 / N543	Pull the clinical notes. Write a letter of medical necessity. File a formal appeal with documentation.
Secondary payer owes nothing	51	Zero out the secondary balance. Service has been paid in full by primary. No patient billing needed.
Wrong place of service	M20 / N570	Find the correct 2-digit POS code for where service was actually provided. Correct and resubmit claim.

Common Mistakes That Lead to Denials

Mistake	Why It Happens	How To Avoid It
Submitting claims past the timely filing deadline	Staff forget to track claim submission dates	Set a 30-day internal deadline. Run weekly aging reports to catch unbilled claims early.
Missing prior authorization	Service scheduled without checking auth requirements	Check auth requirements before scheduling. Create a checklist by payer for common procedures.
Wrong diagnosis code for the service	Copy-paste error or outdated ICD-10 code used	Use only current-year ICD-10 codes. Train staff to verify codes match the documented diagnosis.
Incorrect patient insurance information	Old card on file or patient did not update their plan	Verify insurance at every visit. Scan front and back of insurance card each time.
Billing bundled codes separately	Coder does not know NCCI bundling rules	Use a billing system with NCCI edits enabled. Check bundling before submitting.

Mistake	Why It Happens	How To Avoid It
Not following up on unpaid claims	Staff assume claim is being processed	Set follow-up reminders for all claims not paid within 30 days of submission.