The Medical Claim Denial Code Cheat Sheet

The 20 CARC/RARC Denial Codes Independent Practices See Most — Decoded, With the Exact Next Action for Each

For: Practice managers, billing coordinators, and front-office staff at independent medical practices (Tampa Bay and beyond) who handle claim denials in-house and need a faster, more consistent way to resolve them without escalating every denial to a senior biller.

You will learn: Stop losing hours to Google searches and payer portals every time a claim bounces back. This desk reference decodes the 20 CARC and RARC denial codes independent practices see most often, tells you exactly what each one means in plain English, and gives your team the specific next action to resolve or appeal it — so denied revenue gets recovered in days, not written off in silence.

How to Use This Cheat Sheet

Every denial on an Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA) carries two types of codes:

- **CARC (Claim Adjustment Reason Code)** — the why behind the adjustment or denial (e.g., CO-29, PR-1)
- **RARC (Remittance Advice Remark Code)** — additional detail that clarifies the CARC (e.g., N130, N115)

The prefix on a CARC tells you who is financially responsible for the adjustment:

- **CO** = Contractual Obligation — the practice must write it off or fix and resubmit; the patient cannot be billed
- **PR** = Patient Responsibility — the balance can be legally transferred to the patient
- **OA** = Other Adjustment — situational, read the remark code
- **PI** = Payer Initiated — payer-specific reduction, often appealable

Print this guide, laminate it, or pin it above the biller's desk. When a denial hits your clearinghouse report, find the code below and follow the action — don't start from scratch every time.

Section 1: Patient Financial Responsibility Codes

These are not true "denials" — they're contractual cost-shares. Misreading them as denials wastes staff time; misapplying them creates patient billing errors.

PR-1 — Deductible Amount

Means: The billed amount applies to the patient's unmet deductible.

Next action: Verify the deductible amount against the payer portal, then transfer the balance to the patient statement. No appeal needed — confirm eligibility was checked at time of service to prevent surprise balances going forward.

PR-2 — Coinsurance Amount

Means: The patient owes their contracted percentage share after the deductible is met.

Next action: Confirm the coinsurance percentage matches the patient's plan, then bill the patient. Flag repeat high-coinsurance patients for a financial counseling conversation at check-in.

PR-3 — Copayment Amount

Means: A fixed copay was not collected at time of service.

Next action: Bill the patient, and tighten front-desk collection workflow — every uncollected copay is an A/R item that costs more to chase than to collect upfront.

Section 2: Eligibility & Coverage Denials

The single most preventable — and most common — denial category. All three below trace back to a verification gap.

CO-27 — Expenses Incurred After Coverage Terminated

Means: The patient's policy was inactive on the date of service.

Next action: Re-verify eligibility for the date of service. If the patient had different coverage that day, obtain the correct payer/ID and rebill. If truly uninsured on that date, the balance shifts to the patient (with proper notice).

CO-31 — Patient Cannot Be Identified as Insured

Means: The member ID, name, or DOB submitted doesn't match the payer's file.

Next action: Pull a copy of the insurance card, correct the demographic mismatch, and resubmit as a corrected claim — do not send a duplicate.

CO-22 — This Care May Be Covered by Another Payer (Coordination of Benefits)

Means: The payer believes another insurer is primary.

Next action: Contact the patient to confirm coordination of benefits (COB), update COB on file with the payer if it's outdated, and rebill in correct primary/secondary order.

Section 3: Authorization & Timely Filing Denials

These denials are almost always avoidable at the front end — and almost always non-appealable once the window closes, which is why speed matters more than anywhere else on this list.

CO-15 — Missing or Invalid Authorization Number

Means: The claim was billed without a required prior authorization reference.

Next action: Check the authorization log for a valid number. If one exists, resubmit as corrected. If none exists, contact the payer immediately to request a retroactive authorization — many payers allow this within a short window if requested fast.

CO-197 — Precertification/Authorization/Notification Absent

Means: No prior authorization or notification was on file before the service.

Next action: File an appeal with clinical documentation demonstrating medical necessity and, where applicable, urgency. Build a hard-stop in scheduling so no auth-required procedure is booked without a confirmed number.

CO-29 — Timely Filing Limit Expired

Means: The claim was submitted after the payer's filing deadline.

Next action: Check your clearinghouse's original submission date-stamp — if the claim was filed on time but rejected/re-routed, that proof can overturn the denial on appeal. If truly late, this is typically a hard loss; use it to audit why the claim sat unbilled and fix the workflow gap.

Section 4: Coding & Modifier Errors

These denials point to a coding, not a coverage, problem — resolve at the claim level, not with the patient.

CO-4 — Procedure Code Inconsistent with Modifier Used

Means: The modifier appended doesn't logically apply to the CPT/HCPCS code billed.

Next action: Review the modifier against CPT guidelines (e.g., -25, -59, -RT/-LT), correct it, and resubmit as a corrected claim.

CO-5 — Procedure Code Inconsistent with Place of Service

Means: The billed service isn't payable in the setting indicated (e.g., a facility-only code billed from an office POS).

Next action: Confirm the correct place-of-service code for where the service actually occurred and rebill.

CO-11 — Diagnosis Inconsistent with Procedure

Means: The ICD-10 code doesn't support medical necessity for the CPT billed under payer policy.

Next action: Pull the chart note, confirm the most specific supporting diagnosis was used, correct if needed, and resubmit. If the documentation genuinely supports the original diagnosis, appeal with the note attached rather than changing the code to "make it fit."

Section 5: Missing Information & Duplicate Claims

CO-16 — Claim/Service Lacks Information Needed for Adjudication

Means: Something on the claim is incomplete — almost always paired with a specific RARC (e.g., missing NPI, missing modifier, missing referring provider).

Next action: Read the accompanying RARC carefully — it names the exact missing field. Correct that field only and resubmit; do not guess at the whole claim.

CO-18 — Duplicate Claim/Service

Means: The payer's system already has a claim on file for this same date, provider, and procedure.

Next action: Search your clearinghouse for the original claim status. If it's still processing, take no action — resubmitting again only restarts the clock. If the original was denied for a different reason, correct and resubmit that claim, referencing the original claim number.

Section 6: Bundling & Medical Necessity Denials

CO-97 — Payment Adjusted Because the Benefit for This Service Is Included in the Payment for Another Service

Means: The procedure is bundled into another code billed the same day (NCCI edit).

Next action: Confirm whether a modifier (e.g., -59, -XU) is appropriate to unbundle a genuinely separate, distinct service. If justified by documentation, append the modifier and appeal; if the bundling is correct, write off and move on.

CO-50 — These Are Non-Covered Services Because This Is Not Deemed a Medical Necessity

Means: The payer's clinical policy doesn't support the service for the diagnosis billed.

Next action: Pull the payer's Local Coverage Determination (LCD) or medical policy, compare against the chart documentation, and appeal with supporting clinical notes if the criteria were met. If not met, this is typically patient-responsible with an Advance Beneficiary Notice (ABN) on file.

CO-96 — Non-Covered Charge

Means: The service is excluded from the patient's specific plan benefits.

Next action: Verify plan exclusions before appealing — this is rarely appealable. If confirmed excluded and no ABN/waiver was signed, this is likely a practice write-off, which is exactly why front-desk benefit verification matters.

CO-109 — Claim Not Covered by This Payer/Contractor

Means: You billed the wrong payer entirely (e.g., a Medicare Advantage plan instead of Original Medicare).

Next action: Re-verify eligibility to identify the correct payer and rebill immediately — timely filing clocks don't pause for this error.

CO-149 — Lifetime Benefit Maximum Has Been Reached

Means: The patient has exhausted their plan's lifetime allowance for this service category.

Next action: Confirm with the payer, then bill the patient directly if the service was pre-disclosed as a possible self-pay scenario. Not appealable in most cases.

Section 7: Fee Schedule & Payment Adjustments

CO-45 — Charge Exceeds Fee Schedule/Maximum Allowable or Contracted/Legislated Fee Arrangement

Means: You billed more than the contracted rate; the payer adjusted down to the allowed amount.

Next action: This is a normal contractual adjustment, not a true denial — confirm the allowed amount matches your current fee schedule, and write off the difference. If the allowed amount looks wrong, request the current fee schedule from the payer and compare line by line; underpayments here compound quietly across hundreds of claims.

The 48-Hour Denial Triage Rule

Codes alone don't recover revenue — a process does. Independent practices that resolve denials fastest all follow one rule: **every denial gets touched within 48 hours of posting.**

1. **Sort** — Separate CO (practice-owed) from PR (patient-owed) denials immediately.

2. **Match** — Find the code on this sheet and identify the next action before opening the payer portal.

3. **Act** — Correct-and-resubmit or appeal the same day where possible; every day a denial sits is a day closer to the appeal deadline.

4. **Track** — Log denial codes by frequency and payer. If one code (like CO-27 or CO-197) keeps recurring, the fix belongs at check-in or scheduling, not in the billing office.

A practice denying 8-10% of claims and correcting reactively is leaving 3-5% of collectible revenue on the table every single month.

When It's Time to Bring in Reinforcements

This cheat sheet solves the individual denial. But if your team is drowning in a backlog, seeing the same codes repeat month after month, or losing appeal-deadline claims to sheer volume, the underlying issue usually isn't your biller's knowledge — it's bandwidth and process.

ClaimCarePro works exclusively with independent practices across the Tampa Bay area on exactly these problems:

- **Denial Management & Appeals** — dedicated follow-up on every CO and PI denial until it's resolved, not just resubmitted
- **A/R Cleanup & Recovery** — targeted recovery of aging claims stuck in the 90/120+ day buckets
- **Full-Service Medical Billing & Coding (RCM)** — end-to-end claims management so denials get caught before timely filing runs out
- **Credentialing & Payer Enrollment** — preventing CO-109 and enrollment-related denials before they start
- **Free A/R Audit** — a no-cost look at your current denial rate, top denial codes, and recoverable revenue

Want to know exactly how much denied and aging revenue is sitting in your A/R right now? Claim your Free A/R Audit from ClaimCarePro — our Tampa Bay-based team will identify your top denial codes, quantify recoverable revenue, and show you where your process is leaking money, no obligation required.