RCM Denial Codes (CARC / RARC)

Adjustment groups, common reason codes & the recovery workflow

Objective: Read a remittance, classify the denial, and pick the correct recovery action.

Adjustment groups (who owes)

- **CO — Contractual Obligation** — Provider write-off per contract. CANNOT be billed to the patient.
- **PR — Patient Responsibility** — Deductible / coinsurance / copay. Bill the patient.
- **OA — Other Adjustment** — Used when neither CO nor PR applies.
- **PI — Payer Initiated** — Payer's reduction not covered by a contract clause.

Common CARC codes

Code	Meaning	Typical action
CO-16	Missing / incomplete information	Read the RARC, correct & resubmit
CO-18	Duplicate claim or service	Do not resubmit — verify
CO-22	Covered by another payer (COB)	Bill the primary payer first
CO-29	Timely filing limit expired	Appeal with proof of timely filing
CO-45	Charge exceeds fee schedule	Contractual write-off
CO-50	Not deemed medically necessary	Review dx linkage; corrected claim / appeal
CO-97	Bundled into another service	Check NCCI edits; appeal if separately payable
CO-109	Not covered by this payer	Bill the correct payer
CO-197	Pre-cert / authorization absent	Retro-auth if allowed, then appeal
PR-1 / PR-2 / PR-3	Deductible / Coinsurance / Copay	Bill the patient

RARC & workflow

- RARC (Remittance Advice Remark Codes, N- and M- prefixed) explain or supplement the CARC — always read them to learn WHAT is missing.
- Workflow: read the CARC ’ identify the group (CO vs PR) ’ PR? bill the patient · CO? correct or appeal — never balance-bill a CO write-off.