Denial codes cheat sheet: the top 20 CARC codes

Official meanings are the X12 Claim Adjustment Reason Code text, checked against the X12 code list in August 2026. The number is what X12 defines. The group prefix (CO, PR, OA, PI) is assigned by the payer when the claim adjudicates, so the prefix you see can vary.

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CODE	OFFICIAL X12 MEANING	WHAT USUALLY WENT WRONG	FIRST ACTION
PR-1	Deductible Amount	The patient has not met their deductible.	**Bill the patient** for the amount shown.
PR-2	Coinsurance Amount	The patient's percentage share of the allowed amount.	**Bill the patient**, or the secondary payer if there is one.
PR-3	Co-payment Amount	The flat per-visit fee the plan charges.	**Bill the patient**, or reconcile against the copay taken at check-in.
CO-4	The procedure code is inconsistent with the modifier used.	A required modifier is missing or invalid for that CPT code.	**Corrected claim**. Medicare returns these unprocessable, so send a new claim.
CO-11	The diagnosis is inconsistent with the procedure.	The ICD-10 code does not support the procedure billed.	**Corrected claim** after recoding from the chart.
CO-16	Claim/service lacks information or has submission/billing error(s).	A required field is missing. The paired remark code names it.	**Corrected claim**. With MA130 there are no appeal rights, so resubmit new.
OA-18	Exact duplicate claim/service	The same service, date and provider were billed twice.	Check claim status. If the first one paid, **post it and close** the duplicate.
CO-22	This care may be covered by another payer per coordination of benefits.	Another plan is primary and has not paid yet.	Bill the primary payer, then **resubmit** with its remittance.
CO-27	Expenses incurred after coverage terminated.	The policy had ended on the date of service.	Look for a replacement policy. If none, **bill the patient**.
CO-29	The time limit for filing has expired.	The claim missed the payer's filing deadline.	**Appeal** only with proof of timely filing. Otherwise **write off**.
CO-45	Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.	Your charge sits above the contracted rate. Not a denial.	**Write off**. Never bill the patient for a CO adjustment.
CO-50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	Coverage policy was not met, or the diagnosis did not support it.	**Appeal** with chart notes, or bill the patient if a signed waiver exists.
CO-96	Non-covered charge(s).	The plan excludes the service outright.	Read the remark code. If excluded by law or contract, **bill the patient**.
CO-97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	The service bundles into another one billed the same day.	Check the bundling edits. **Appeal** with a modifier only if it was genuinely separate.
CO-109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	Wrong payer. The patient has a different plan or contractor.	Re-verify eligibility, then **submit to the correct payer**.
CO-151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	More units or visits were billed than the policy allows.	**Appeal** with documentation for the volume, or **write off** the excess.
CO-167	This (these) diagnosis(es) is (are) not covered.	The diagnosis itself is excluded from the plan.	Confirm the coding is right. If it is, **bill the patient**.
CO-197	Precertification/authorization/notification/pre-treatment absent.	No prior authorization was on file when the claim processed.	Request a retroactive authorization, then **appeal** if the payer refuses.
PR-204	This service/equipment/drug is not covered under the patient's current benefit plan	The plan simply does not include this benefit.	**Bill the patient**, provided your financial policy covers it.
CO-252	An attachment/other documentation is required to adjudicate this claim/ service.	The payer wants records before it will decide.	Send the records with a **corrected claim**. This is not an appeal.

THE GROUP PREFIX

CO Contractual Obligation. The practice absorbs it and cannot bill the patient.

PR Patient Responsibility. The amount can be billed to the patient.

OA Other Adjustment. Used when no other group code applies.

PI Payor Initiated Reduction. Medicare does not use it. Only CO, OA and PR are valid on a Medicare remittance.

WHICH RESPONSE?

Corrected claim
Data was wrong or missing. Frequency code 7 replaces the claim, 8 voids it.

Appeal
You disagree on coverage or necessity. Medicare allows 120 days from receipt of the determination.

Bill the patient
The adjustment carries a PR group code.

Write off
A CO contractual adjustment, or a deadline you genuinely missed.

READING IT ON THE ERA

Each adjustment carries a group code, a reason code and an amount. Remark codes add the detail.

Example: CO / 50 / N115 means Medicare denied for medical necessity under a Local Coverage Determination, and you absorb it unless you appeal.

Sources: X12 Claim Adjustment Reason Codes and Remittance Advice Remark Codes (x12.org/codes); CMS Medicare Claims Processing Manual, Chapter 22; Novitas Solutions top claim denials, April–June 2026.

pabau.com/blog/denial-codes-in-medical-billing