CARC and RARC values used by Mississippi Division of Medicaid

CARC codes and their associated messages are identified in the following table:

CARC	CARC Message
A8	Ungroupable DRG.
B1	Non-covered visits.
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.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
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.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
3	Co-payment Amount
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.
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.
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.
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.
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.
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.
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.
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.

CARC	CARC Message
13	The date of death precedes the date of service.
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.
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
22	This care may be covered by another payer per coordination of benefits.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
24	Charges are covered under a capitation agreement/managed care plan.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
32	Our records indicate the patient is not an eligible dependent.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
39	Services denied at the time authorization/pre-certification was requested.
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)
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.
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.
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.
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.
94	Processed in Excess of Charges
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.
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.
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.

CARC	CARC Message
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
110	Billing date predates service date.
119	Benefit maximum for this time period or occurrence has been reached.
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
140	Patient/Insured health identification number and name do not match.
142	Monthly Medicaid patient liability amount.
146	Diagnosis was invalid for the date(s) of service reported.
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.
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.
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.
177	Patient has not met the required eligibility requirements.
181	Procedure code was invalid on the date of service.
197	Precertification/authorization/notification/pre-treatment absent.
198	Precertification/notification/authorization/pre-treatment exceeded.
199	Revenue code and Procedure code do not match.
204	This service/equipment/drug is not covered under the patient's current benefit plan
206	National Provider Identifier - missing.
207	National Provider identifier - Invalid format
208	National Provider Identifier - Not matched.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
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.
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
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).
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).
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
272	Coverage/program guidelines were not met.

CARC	CARC Message
273	Coverage/program guidelines were exceeded.
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.

RARC codes and their associated messages are identified in the following table:

RARC	RARC Message
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M20	Missing/incomplete/invalid HCPCS.
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
M44	Missing/incomplete/invalid condition code.
M45	Missing/incomplete/invalid occurrence code(s).
M46	Missing/incomplete/invalid occurrence span code(s).
M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
M49	Missing/incomplete/invalid value code(s) or amount(s).
M50	Missing/incomplete/invalid revenue code(s).
M51	Missing/incomplete/invalid procedure code(s).
M52	Missing/incomplete/invalid “from” date(s) of service.
M53	Missing/incomplete/invalid days or units of service.
M54	Missing/incomplete/invalid total charges.
M56	Missing/incomplete/invalid payer identifier.
M59	Missing/incomplete/invalid “to” date(s) of service.
M60	Missing Certificate of Medical Necessity.
M62	Missing/incomplete/invalid treatment authorization code.
M64	Missing/incomplete/invalid other diagnosis.
M67	Missing/incomplete/invalid other procedure code(s).
M76	Missing/incomplete/invalid diagnosis or condition.
M77	Missing/incomplete/invalid/inappropriate place of service.
M79	Missing/incomplete/invalid charge.
M81	You are required to code to the highest level of specificity.
M86	Service denied because payment already made for same/similar procedure within set time frame.

RARC	RARC Message
M90	Not covered more than once in a 12 month period.
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
M126	Missing/incomplete/invalid individual lab codes included in the test.
M139	Denied services exceed the coverage limit for the demonstration.
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
MA30	Missing/incomplete/invalid type of bill.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32	Missing/incomplete/invalid number of covered days during the billing period.
MA36	Missing/incomplete/invalid patient name.
MA39	Missing/incomplete/invalid gender.
MA40	Missing/incomplete/invalid admission date.
MA41	Missing/incomplete/invalid admission type.
MA42	Missing/incomplete/invalid admission source.
MA43	Missing/incomplete/invalid patient status.
MA63	Missing/incomplete/invalid principal diagnosis.
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65	Missing/incomplete/invalid admitting diagnosis.
MA66	Missing/incomplete/invalid principal procedure code.
MA92	Missing plan information for other insurance.
MA120	Missing/incomplete/invalid CLIA certification number.
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
N3	Missing consent form.
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
N20	Service not payable with other service rendered on the same date.
N27	Missing/incomplete/invalid treatment number.
N28	Consent form requirements not fulfilled.
N30	Patient ineligible for this service.
N34	Incorrect claim form/format for this service.

RARC	RARC Message
N35	Program integrity/utilization review decision.
N36	Claim must meet primary payer's processing requirements before we can consider payment.
N37	Missing/incomplete/invalid tooth number/letter.
N39	Procedure code is not compatible with tooth number/letter.
N43	Bed hold or leave days exceeded.
N45	Payment based on authorized amount.
N46	Missing/incomplete/invalid admission hour.
N50	Missing/incomplete/invalid discharge information.
N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
N54	Claim information is inconsistent with pre-certified/authorized services.
N55	Procedures for billing with group/referring/performing providers were not followed.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N58	Missing/incomplete/invalid patient liability amount.
N61	Rebill services on separate claims.
N62	Dates of service span multiple rate periods. Resubmit separate claims.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N75	Missing/incomplete/invalid tooth surface information.
N77	Missing/incomplete/invalid designated provider number.
N90	Covered only when performed by the attending physician.
N95	Covered only when performed by the attending physician.
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.
N117	This service is paid only once in a patient's lifetime.
N122	Add-on code cannot be billed by itself.
N129	Not eligible due to the patient's age.
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
N143	The patient was not in a hospice program during all or part of the service dates billed.
N152	Missing/incomplete/invalid replacement claim information.

RARC	RARC Message
N180	This item or service does not meet the criteria for the category under which it was billed.
N190	Missing contract indicator.
N198	Rendering provider must be affiliated with the pay-to provider.
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
N232	Incomplete/invalid itemized bill/statement.
N253	Missing/incomplete/invalid attending provider primary identifier.
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
N277	Missing/incomplete/invalid other payer rendering provider identifier.
N280	Missing/incomplete/invalid pay-to provider primary identifier.
N286	Missing/incomplete/invalid referring provider primary identifier.
N288	Missing/incomplete/invalid rendering provider taxonomy.
N290	Missing/incomplete/invalid rendering provider primary identifier.
N299	Missing/incomplete/invalid occurrence date(s).
N300	Missing/incomplete/invalid occurrence span date(s).
N301	Missing/incomplete/invalid procedure date(s).
N305	Missing/incomplete/invalid injury/accident date.
N307	Missing/incomplete/invalid adjudication or payment date.
N321	Missing/incomplete/invalid last admission period.
N329	Missing/incomplete/invalid patient birth date.
N351	Service date outside of the approved treatment plan service dates.
N354	Incomplete/invalid invoice.
N362	The number of Days or Units of Service exceeds our acceptable maximum.
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
N382	Missing/incomplete/invalid patient identifier.
N428	Not covered when performed in this place of service.
N434	Missing/Incomplete/Invalid Present on Admission indicator.
N435	Exceeds number/frequency approved /allowed within time period without support documentation.
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N517	Resubmit a new claim with the requested information.

RARC	RARC Message
N519	Invalid combination of HCPCS modifiers.
N521	Mismatch between the submitted provider information and the provider information stored in our system.
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
N563	Alert: Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.
N570	Missing/incomplete/invalid credentialing data.
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
N587	Policy benefits have been exhausted.
N640	Exceeds number/frequency approved/allowed within time period.
N644	Reimbursement has been made according to the bilateral procedure rule.
N646	Reimbursement has been adjusted based on the guidelines for an assistant.
N647	Adjusted based on diagnosis-related group (DRG).
N657	This should be billed with the appropriate code for these services.
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.

CARC and RARC values used by Mississippi Division of Medicaid

The static CARC codes used for common adjudication results and their associated usages by scenario are identified in the following table:

Scenario	Prior to 24 May 2021		As of 24 May 2021			As of 13 Sept 2021		
	Claim Adj Reason Code (CARC)	GRP Code	Claim Adj Reason Code (CARC)	GRP Code	CARC Message	Claim Adj Reason Code (CARC)	GRP Code	CARC Message
The claim is a Void transaction associated with a prior paid claim	125	CR	B13	CR	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	B13	CR	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
The claim is the Credit portion of a claim Adjustment transaction	125	CR	B13	CR		B13	CR	
A Co-Payment Amount has been assessed	B5	PR	272	PR	272 - Coverage/program guidelines were not met.	**3**	PR	**3 - Co-payment Amount**
A Medicare Payment Amount was submitted	23	OA	272	OA		**23**	OA	**23 - The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)**
A Third-Party Payment was submitted	23	PI	272	PI		**23**	**OA**	
Both a Medicare Payment Amount and a Third-Party Payment were submitted	119	PI	272	PI		**23**	**OA**	
A portion of the Billed Charges were not covered by Medicaid	212	PI	272	PI		**23**	**OA**	
Charges exist which are part of the Population Management Health program	24	PI	24	PI	24 - Charges are covered under a capitation agreement/managed care plan.	24	PI	24 - Charges are covered under a capitation agreement/managed care plan.

CARC and RARC values used by Mississippi Division of Medicaid

Scenario	Prior to 24 May 2021		As of 24 May 2021			As of 13 Sept 2021		
	Claim Adj Reason Code (CARC)	GRP Code	Claim Adj Reason Code (CARC)	GRP Code	CARC Message	Claim Adj Reason Code (CARC)	GRP Code	CARC Message
Billed Charges exceed the Medicaid Allowed Amount	50	PI	45	CO	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)	45	CO	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)
The Medicaid allowed amount exceeds the Billed Charges	50	PI	272	PI	272 - Coverage/program guidelines were not met.	**94**	PI	**94 - Processed in Excess of Charges**
The Limit for this service has been exceeded	119	OA	272	OA		**119**	**PI**	**119 - Benefit maximum for this time period or occurrence has been reached.**
A Medicaid Assessment Amount exists for the claim	212	PI	272	PI		**137**	PI	**137 - Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.**
The Patient/Medicaid Beneficiary is liable for a portion of the amount of the monthly charges associated with their care	B5	PR	272	PR		**142**	PR	**142 - Monthly Medicaid patient liability amount.**

Note: Red text indicates changes

Note: Red Bold text indicates changes