Claim Adjustment Reason Codes (CARCs)
Remittance Advice Remark Codes (RARCs)

Workers' Compensation Board

Effective July 1, 2021, Payers will be required to use the following Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) on an explanation of benefits (EOB) sent to a health care provider to object to payment of a medical bill. The Payer must send the Workers' Compensation Board (Board) a timely filed ***Notice of Treatment Issue/Disputed Bill Part B (Form C-8.1)*** or ***Notice to Health Care Provider and Injured Worker of a Carrier's Refusal to Pay All (or a Portion of) a Medical Bill Due to Valuation Objection(s) (Form C-8.4)*** with the same objection reason noted to properly object to such payment.

Line #	Current Form C-8.1 Part B/C-8.4 Objections	Proposed EOB Objections	CARC RARC	Scenario	Law/Reg/Notes
1	Claim has been controverted by a denial dated _________ and liability has not been resolved	Claim has been controverted by a denial dated __ and: **1.** Establishment is pending	P8	Payer uses **CARC P8** (claim is under investigation) to object to payment of a bill for medical services. The payer has disputed liability for the claim by filing a ***Notice of Controversy*** pursuant to Workers Compensation Law (WLC) 25(2)(b) AND the claim is being investigated for compensability.	WCL § 10
2	N/A	Claim has been controverted by a denial dated __ and: **2.** The case has been disallowed	P4	Payer uses **CARC P4** (workers' compensation claim adjudicated as noncompensable. This Payer not liable for claim or service/ treatment) to object to payment of a bill for medication services. Payer has disputed liability for the claim by filing a ***Notice of Controversy*** pursuant to WCL 25(2)(b) AND the claim has been adjudicated and the Payer has been found not liable for the claim (claim was disallowed).	WCL § 10
3	Prior authorization was not granted for treatment over $1,000.00	Prior authorization was not granted: for: **1.** treatment for a non-emergency special service not covered in the ***New York Workers' Compensation Medical Treatment Guidelines (MTG)*** that was over $1,000.00	198 plus 1 + RARCs	Payer uses **CARC 198** (precertification/authorization exceeded) to object to payment of a bill when prior authorization was not granted for medical services (line or claim level amount >$1,000). These are services for non-***MTG*** body parts, or non-emergency services or special services. Payer should use appropriate RARC(s).	WCL § 13-a(5) 12 NYCRR* 325-1.4 12 NYCRR 324.2 **New York Codes, Rules and Regulations*

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4	N/A	Prior authorization was not granted for: **2.** continuous course of treatment for physical therapy/occupational therapy (PT/OT) over $1,000.00	198 plus 1 + RARCs	Payer uses **CARC 198** (precertification/authorization exceeded) to object to payment of a bill when prior authorization was not granted for continuous course of treatment for PT/OT medical services (line or claim level amount >$1,000). Payer should use appropriate RARC(s).	WCL § 13-a(5) 12 NYCRR 325-1.4 12 NYCRR 324.2
5	N/A	Prior authorization was not granted for: **3.** ***MTG*** procedure/ treatment requiring prior authorization	198 plus 1 + RARCs	Payer uses **CARC 198** (precertification/authorization exceeded) to object to payment of a bill when prior authorization was not granted for ***MTG*** procedure/treatment. Payer should use appropriate RARC(s). (Section A.13 of the ***MTG***, "General Guideline Principles," lists procedures that require prior authorizations).	WCL § 13-a(5) 12 NYCRR 325-1.4 12 NYCRR 324.2
6	Request for treatment has been denied, withdrawn, or refused	Request for treatment has been denied, withdrawn, or refused	39 w/wo 1 + RARCs – M62, N30, N202, N362, N473, N474, N485, N486, N533	Payer uses **CARC 39** (Services denied at the time authorization/ pre-certification was requested.) to object to payment of a bill when: authorization has been denied by the payer; the doctor has withdrawn the request for authorization; or the claimant has decided to not proceed with the requested treatment. Payer can also use any of the following RARCs — **M62, N30, N202, N362, N473, N474, N485, N486, N533**.	
7	Treatment provided was not causally related to the compensable injury	Treatment provided was: **1.** for a non-established body site or for a body site that the employer/ carrier has not accepted liability for	P2	Payer uses **CARC P2** (Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.) to object to payment of a bill for a non-established body site or for a body site that the employer/carrier has not accepted liability for.	WCL § 2(7) WCL § 10 WCL § 13
8	N/A	Treatment provided was: **2.** for an established body site, but was not causally related to the compensable injury	50	Payer uses **CARC 50** (Non-covered services because it is not deemed a "medical necessity" by the Payer.) to object to payment of a bill for an established body site, but was not causally related to the compensable injury.	WCL § 2(7) WCL § 10 WCL § 13

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9	N/A	Treatment provided was: **3.** for a body site that is the subject of multiple claims and the injury is not related to claim at issue	109	Payer uses **CARC 109** (Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.) to object to payment of a bill for a body site that is the subject of multiple claims and the injury is not related to claim at issue.	WCL § 2(7) WCL § 10 WCL § 13
10	Treatment provided within 30 days of initial treatment was outside of preferred provider organization (PPO)	Treatment provided within 30 days of initial treatment was outside of preferred provider organization (PPO)	279	Payer uses **CARC 279** (Services not provided by preferred provider network.) to object to payment of a bill when the claimant sought treatment from a provider who is not part of a contracted New York State workers' compensation (NYS WC) certified PPO.	12 NYCRR 325-8.1 (See list of active PPOs on Board website)
11	Medical report for treatment was not timely filed or is legally defective	Medical report for treatment was: **1.** Not timely filed	164 w/wo 1 + RARCs	Payer uses **CARC 164** (Attachment/other documentation referenced on the claim was not received in a timely fashion.) to object to payment of a bill when the medical report for treatment was not timely filed. Payer can also use any appropriate RARCs.	WCL § 13-a(4)(a) 12 NYCRR 325-1.25 12 NYCRR 325-1.3
12	N/A	Medical report for treatment was: **2.** Incomplete	251 w/wo 1 + RARCs	Payer uses **CARC 251** (attachment/other documentation was incomplete or deficient) to object to payment of a bill when the medical report is incomplete or deficient. Payer can also use any appropriate RARCs.	WCL § 13-a(4)(a) 12 NYCRR 325-1.25 12 NYCRR 325-1.3
13	Medical appliance or program is not covered under the WCL	Medical appliance or program is not covered under the WCL **1.** Letter of medical necessity not included	P13 plus RARC M60	Payer uses **CARC P13** (Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies; use only if no other code is applicable.) to deny payment of a bill when letter of medical necessity is not included. Payer should also use **RARC M60** (missing certificate of medical necessity).	WCL § 13(a)
14	N/A	Medical appliance or program is not covered under the WCL **2.** Insufficient documentation provided	P13 plus RARC M135	Payer uses **CARC P13** (Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies; use only if no other code is applicable.) to deny payment of a bill when insufficient documentation is provided. Payer should also use **RARC M135** (missing/incomplete/invalid plan of treatment).	WCL § 13(a)

Line #	Current Form C-8.1 Part B/C-8.4 Objections	Proposed EOB Objections	CARC RARC	Scenario	Law/Reg/Notes
15	Provider is not authorized under WCL	Provider is not authorized under the WCL and exceptions under WCL § 13-b do not apply	P16	Payer uses **CARC P16** (Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for workers' compensation only.) to object to payment of a bill when treatment was rendered by a provider who is not authorized under the WCL. Payers are not obligated to pay for treatment by unauthorized physician except for enumerated exceptions listed in WCL 13-b.	WCL § 13-a WCL § 13-b
16	Bill is not for treatment, but for an evidentiary opinion	Bill is not for treatment, but for an evidentiary opinion/review of records or submission of a report made without physical examination as defined in 12 NYCRR 300.2(b)(12)	96 plus RARC N717	Payer uses **CARC 96** (non-covered charge) to object to payment of a bill when the bill is for an evidentiary opinion or a review of records or submission of a report made without physical examination (e.g., IME exam, records review, etc.) Payer should use appropriate **RARC N717** (incomplete/invalid documentation of face-to-face examination).	12 NYCRR 300.2(b)(12)
17	Diagnostic test was performed outside of network	Diagnostic test was performed outside of network	243	Payer uses **CARC 243** (Services not authorized by network/primary care providers.) to object to payment of a bill when diagnostic testing was performed outside of diagnostic testing network (DTN).	WCL § 13-a (7) 12 NYCRR 325-7
18	Diagnostic test was performed outside of network	Pharmacy outside of network	242	Payer uses **CARC 242** (Services not provided by network/primary care providers.) to object to payment of a bill when an out of network pharmacy (PBM) was utilized.	WCL § 13-a (7) 12 NYCRR 325-7
19	**1.** Treatment provided was not based on correct application of the guidelines	Compliance with ***MTG: 1***. Treatment provided was not based on correct application of the guidelines	272	Payer uses **CARC 272** (Coverage/program guidelines were not met.) to object to payment of a bill when treatment provided was not based on correct application of the ***MTG***.	***MTG*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
20	**2.** Treatment deviates from the guidelines without securing a variance	Compliance with ***MTG: 2***. Treatment deviates from the guidelines without securing a variance	197	Payer uses **CARC 197** (precertification/authorization/notification/pre-treatment absent) to object to payment of a bill when treatment deviates from the ***MTG*** without securing a variance.	***MTG*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)

Line #	Current Form C-8.1 Part B/C-8.4 Objections	Proposed EOB Objections	CARC RARC	Scenario	Law/Reg/Notes
21	**3.** Treatment not consistent with the approved variance	Compliance with ***MTG: 3***. Treatment not consistent with the approved variance	198 plus 1 + RARCs	Payer uses **CARC 198** (precertification/authorization exceeded) to object to payment of a bill when treatment is not consistent with the approved variance. Payer should use one or more appropriate RARC codes.	***MTG*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
22	**4.** Variance denied without claimant timely requesting review or variance denied by Board decision	Compliance with ***MTG: 4***. Variance denied without claimant timely requesting review or variance denied by Board decision	39	Payer uses **CARC 39** (Services denied at the time authorization/ pre-certification was requested.) to object to payment of a bill when variance denied without claimant timely requesting review or variance denied by Board decision.	***MTG*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
23	N/A	Compliance with ***MTG: 5***. Exacerbation (exception to variance requirement for continued treatment) **a.** Information incomplete	273 plus RARC N705	Payer uses **CARC 273** (Coverage guidelines were exceeded — pending new code.) to deny payment of a bill when exacerbation treatments exceeded the ***MTG***. Payer should also use **RARC N705** (incomplete/invalid documentation).	12 NYCRR 324.2 (f) ***Neck Injury MTG*** D.11.d.i. ***Mid and Low Back Injury MTG*** D.10.a.i.
24	N/A	Compliance with ***MTG: 5***. Exacerbation (exception to variance requirement for continued treatment) **b.** Treatment exceeds guidelines	273 plus RARC N435	Payer uses **CARC 273** (Coverage guidelines were exceeded — pending new code.) to deny payment of a bill when exacerbation treatments exceeded the ***MTG***. Payer should also use **RARC N435** (exceeds number/frequency approved/allowed within time period without support documentation).	12 NYCRR 324.2 (f) ***Neck Injury MTG*** D.11.d.i. ***Mid and Low Back Injury MTG*** D.10.a.i.
25	N/A	Compliance with ***MTG: 6***. Urine drug screens **a.** Insufficient documentation	272 plus RARC N705	Payer uses **CARC 272** (Coverage/program guidelines were not met.) to deny payment of a bill when urine drug screens have insufficient documentation. Payer should also use **RARC N705** (incomplete/invalid documentation).	12 NYCRR 324.2 NAP F.3.i

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26	N/A	Compliance with ***MTG: 6***. Urine drug screens **b.** Incorrect testing used/other	272 plus RARC N623	Payer uses **CARC 272** (Coverage/program guidelines were not met.) to deny payment of a bill for urine drug screens when inappropriate or incorrect testing was used or other reasons — for example excessive testing. Payer should also use **RARC N62** (not covered when deemed unscientific/unproven/outmoded/ experimental/excessive/inappropriate).	12 NYCRR 324.2 NAP F.3.i
27	Amount of bill: is excessive or not in accordance with pertinent ***New York Workers' Compensation Fee Schedule (NY WC Fee Schedule)***	Amount of bill: is excessive or not in accordance with pertinent ***NY WC Fee Schedule***	P12	Payer uses **CARC P12** (workers' compensation jurisdictional fee schedule adjustment) to object to payment of a bill when the bill (line or claim level) is excessive or not in accordance with the ***NY WC Fee Schedule***.	WCL 13(a) ***NY WC Fee Schedule***, incorporated by reference in 12 NYCRR 329-1.3
28	Amount of bill: has not been properly pro-rated or apportioned between providers	Amount of bill: has not been properly pro-rated or apportioned between providers	B20	Payer uses **CARC B20** (Procedure/service was partially or fully furnished by another provider.) to object to payment of a bill when the claimant is transferred from one physician to another and the bill is not properly pro-rated or apportioned between providers.	12 NYCRR 329.3 see "General Ground Rule" #8 entitled "Proration of Scheduled Unit Fee": "When the schedule specifies a unit fee for a definite treatment with an inclusive period of alter care (follow-up), and the patient is transferred from one physician to another physician, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the physicians."

Line #	Current Form C-8.1 Part B/C-8.4 Objections	Proposed EOB Objections	CARC RARC	Scenario	Law/Reg/Notes
29	Amount of bill: uses improper CPT codes	Amount of bill: uses improper CPT codes	P13 plus RARC M51	Payer uses **CARC P13** (Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies; use only if no other code is applicable.) to object to payment of a bill when the bill (line level) uses the incorrect CPT code(s) for the treatment rendered. Payer should also use **RARC M51** (missing/incomplete/invalid procedure code(s)).	***NY WC Fee Schedule***
30	Amount of bill: is not in accordance with Ground Rules limitation	Amount of bill: is not in accordance with Ground Rules limitation	P13 plus RARC N130	Payer uses **CARC P13** (Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable) to deny payment of a bill when the bill is not in accordance with a ***NY WC Fee Schedule*** "Ground Rule" limitation (for example: incorrect modifier used). Payer should also use **RARC N130** (Consult plan benefit documents/guidelines for information about restrictions for this service). *Please note: This CARC code cannot be used when raising objections related to Ground Rules or CPT codes addressed in or subject to RVU limitations*	***NY WC Fee Schedule***
31	**1.** Is inappropriate	Treatment: **1.** Is inappropriate	150	Payer uses **CARC 150** (Payer deems the information submitted does not support this level of service.) to deny payment of a bill when treatment provided was inappropriate for the injury sustained.	***NY WC Fee Schedule***
32	**2.** Involves concurrent or overlapping services	Treatment: **2.** Involves concurrent or overlapping services	59	Payer uses **CARC 59** (Processed based on multiple or concurrent procedure rules. For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) to deny payment of a bill when treatment involves concurrent or overlapping services (see the ***NY WC Fee Schedule*** "General Ground Rule" #6).	***NY WC Fee Schedule***
33	**3.** Is duplicative, excessive, or rendered too frequently	Treatment: **3.** Is duplicative, excessive, or rendered too frequently	151	Payer uses **CARC 151** (Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.) to deny payment of a bill when treatment is duplicative, excessive, or rendered too frequently.	***NY WC Fee Schedule***

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34	**4.** Involves unnecessary or excessive hospitalization	Treatment: **4.** Involves unnecessary or excessive hospitalization	151	Payer uses **CARC 51** (Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.) to deny payment of a bill when treatment involves unnecessary or excessive hospitalization.	***NY WC Fee Schedule***
35	**5.** Involves a provider treating outside scope of practice	Treatment: **5.** Involves a provider treating outside scope of practice	185	Payer uses **CARC 185** (The rendering provider is not eligible to perform the service billed.) to deny payment of a bill when treatment involves a provider treating outside scope of practice (see NYS Education Law).	***NY WC Fee Schedule*** NYS Education Law Article 131 Section 6521
36	New Value Objection	Amount of bill: reduced pursuant to PPO agreement	P24	Payer uses **CARC P24** (payment adjusted based on Preferred Provider Organization (PPO)) to object to payment of a bill when the amount of the bill is not in accordance with the contracted fee from a NYS WC certified PPO agreement.	12 NYCRR 325-8.1
37	Amount of bill for dental treatment or treatment outside New York State exceeds community standard	Amount of bill for dental treatment or treatment outside New York State exceeds community standard	P5	Payer uses **CARC P5** (Based on payer reasonable and customary fees.) to object to payment of a bill when the bill is for dental treatment that exceeds the amount listed in the dental fee schedule or for treatment outside New York State that exceeds the community standard.	WCL 13(a)

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The New York State Workers' Compensation Board protects the rights of employees and employers by ensuring the proper delivery of benefits and by promoting compliance with the law. To learn more about the Workers' Compensation Board, visit wcb.ny.gov.