CARC and RARC codes required when objecting to payment of medical bills

Workers' Compensation Board

EFFECTIVE JULY 1, 2022, payers will be required to use the following **Claim Adjustment Reason Codes (CARCs)** and **Remittance Advice Remark Codes (RARCs)** on an explanation of benefits/explanation of review (EOB/EOR) sent to a health care provider to object to payment of a medical bill. The payer must send the New York State Workers' Compensation Board (Board) a timely filed ***Notice of Objection to a Payment of a Bill for Treatment Provided (Form C-8.1B)*** or ***Notice to Health Care Provider and Claimant of an Insurer'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. The objections listed are not the CARC descriptions, but are supporting information for the use of the CARC. CARC descriptions may be found at x12.org/codes/claim-adjustment-reason-codes.

Line #	EOB Objections	Objection Form	CARC RARC	Scenario	Law/Reg/Notes
1	The claim has been controverted by a First Report of Injury (FROI) denial (FROI-04) or Subsequent Report of Injury (SROI) denial (SROI-04) dated ________ and establishment is pending.	C-8.1B	P8	Payer uses **CARC P8** 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	The claim has been controverted by a FROI-04 or SROI-04 dated ________ and the case has been disallowed.	C-8.1B	P4	Payer uses **CARC P4** to object to payment of a bill for medical 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

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3	The prior authorization was not granted for treatment over $1,000.00 (for a non-emergency, special service not covered in the Board's ***New York Medical Treatment Guidelines [MTGs])***.	C-8.1B	198 plus 1 + RARCs	Payer uses **CARC 198** 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 body parts not covered by the ***MTGs***, 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*
4	The prior authorization was not granted for continuous course of treatment for physical therapy/ occupational therapy (PT/OT) over $1,000.00.	C-8.1B	198 plus 1 + RARCs	Payer uses **CARC 198** 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	The prior authorization was not granted for MTG-related procedure/treatment requiring pre-authorization.	C-8.1B	198 plus 1 + RARCs	Payer uses **CARC 198** to object to payment of a bill when prior authorization was not granted for MTG-related procedure/ treatment. Payer should use appropriate RARC(s). (Section A.13 of the ***MTGs***, "General Guideline Principles," lists procedures that require prior authorizations.)	WCL § 13-a(5) 12 NYCRR 325-1.4 12 NYCRR 324.2
6	The request for treatment has been denied, withdrawn, or refused.	C-8.1B	39 w/wo 1 + RARCs: M62, N30, N202, N362, N473, N474	Payer uses **CARC 39** to object to payment of a bill when: authorization has been denied by the payer; the health care provider has withdrawn the request for authorization; or the injured worker has decided to not proceed with the requested treatment. Payer can also use any appropriate RARCs, including **M62, N30, N202, N362, N473, N474**.	
7	The treatment provided was for a non-established body site or for a body site for which the employer/ insurer has not accepted liability.	C-8.1B	P2	Payer uses **CARC P2** to object to payment of a bill for a non-established body site or for a body site for which the insurer has not accepted liability.	WCL § 2(7) WCL § 10 WCL § 13
8	The treatment provided was for an established body site, but was not causally related to the compensable injury.	C-8.1B	50	Payer uses **CARC 50** 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	The treatment provided was for a body site that is the subject of multiple claims and the injury is not related to the claim at issue.	C-8.1B	109	Payer uses **CARC 109** 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	The treatment provided within 30 days of initial treatment was outside of the preferred provider organization (PPO).	C-8.1B	279	Payer uses **CARC 279** to object to payment of a bill when the injured worker 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	The medical report for the treatment was not timely filed.	C-8.1B	164 w/wo 1 + RARCs	Payer uses **CARC 164** 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	The medical report for the treatment was incomplete.	C-8.1B	251 w/wo 1 + RARCs	Payer uses **CARC 251** to object to payment of a bill when the medical report is incomplete, not in the prescribed format 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	The medical appliance or program is not covered under the WCL — the letter of medical necessity was not included.	C-8.1B	P13 plus RARC M60	Payer uses **CARC P13** to deny payment of a bill when letter of medical necessity is not included. Payer should also use **RARC M60**.	WCL § 13(a)
14	The medical appliance or program is not covered under the WCL — insufficient documentation was provided.	C-8.1B	P13 plus RARC M135	Payer uses **CARC P13** to deny payment of a bill when insufficient documentation is provided. Payer should also use **RARC M135**.	WCL § 13(a)
15	The provider is not authorized under the WCL and exceptions under WCL § 13-b do not apply.	C-8.1B	P16	Payer uses **CARC P16** 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	The 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).	C-8.1B	96 plus RARC N717	Payer uses **CARC 96** 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., independent medical examination [IME] exam, records review, etc.). Payer should use appropriate **RARC N717**.	12 NYCRR 300.2(b)(12)

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17	The pharmacy used is outside of the network.	C-8.1B	242	Payer uses **CARC 242** to object to payment of a bill when an out-of-network pharmacy was utilized.	WCL § 13-a (7) 12 NYCRR 325-7
18	The diagnostic test was performed outside of the network.	C-8.1B	243	Payer uses **CARC 243** to object to payment of a bill when diagnostic testing was performed outside of network.	WCL § 13-a (7) 12 NYCRR 325-7
19	Other Objections: The prescription drug bill received by insurer is for a non-formulary drug that requires prior approval. Drug was dispensed/ billed without obtaining approval.	C-8.1B	197 plus RARC N448	Payer uses **CARC 197** to object to payment of a bill when non-formulary drug was dispensed/billed without obtaining prior approval. Payer should also use **RARC N448**.	WCL §13-f 12 NYCRR 441.1(n)(o)
20	Other Objections: The injured worker received a Section 32 settlement covering both future indemnity and medical services. Insurer subsequently received medical bill for services post-settlement date.	C-8.1B	P3 plus RARC N585	Payer uses **CARC P3** to object to payment of a bill for a post-settlement (Section 32) date of service. Payer should also use **RARC N585**.	WCL§ 32 12 NYCRR 300.36
21	Other Objections: The injured worker received a third-party settlement covering both future indemnity and medical services. Insurer subsequently received medical bill for services post-settlement date.	C-8.1B	215 plus RARC N585	Payer uses **CARC 215** to object to payment of a bill for a post-settlement (third-party) date of service. Payer should also use **RARC N585**.	WCL § 29
22	Other Objections: The procedure was performed at an ambulatory surgery center, which is not eligible for a facility fee.	C-8.1B	P20 plus RARC N676	Payer uses **CARC P20** plus **RARC N676** to object to payment of a bill when a procedure is performed at an ambulatory surgery center and is not eligible.	12 NYCRR 329-2 Ambulatory Fee Schedule
23	Other Objections: The name of the injured worker/claimant is incorrect.	C-8.1B	16 plus RARC MA36	Payer uses **CARC 16** plus **RARC MA36** to object to a bill when the name of the injured worker/claimant is incorrect.	

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24	Compliance with ***MTGs:*** The treatment provided was not based on correct application of the guidelines.	C-8.1B	272	Payer uses **CARC 272** to object to payment of a bill when treatment provided was not based on correct application of the ***MTGs***.	***MTGs*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
25	Compliance with ***MTGs:*** The treatment is not consistent with the approved variance.	C-8.1B	198 plus 1 + RARCs	Payer uses **CARC 198** 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.	***MTGs*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
26	Compliance with ***MTGs:*** The treatment deviates from the guidelines without securing a variance.	C-8.1B	197	Payer uses **CARC 197** to object to payment of a bill when treatment deviates from the ***MTGs*** without securing a variance.	***MTGs*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
27	Compliance with ***MTGs***: The urine drug screen has insufficient documentation.	C-8.1B	272 plus RARC N705	Payer uses **CARC 272** to deny payment of a bill when urine drug screens have insufficient documentation. Payer should also use **RARC N705**.	12 NYCRR 324.2 ***Non-Acute Pain MTGs*** F.3.d.i.
28	Compliance with ***MTGs***: An incorrect testing method was used on the urine drug screen.	C-8.1B	272 plus RARC N623	Payer uses **CARC 272** 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 N623**.	12 NYCRR 324.2 ***Non-Acute Pain MTGs*** F.3.d.i.
29	Compliance with ***MTGs***: The variance was denied without the claimant timely requesting review or was denied by Board decision.	C-8.1B	39	Payer uses **CARC 39** to object to payment of a bill when variance denied without claimant timely requesting review or variance denied by Board decision.	***MTGs*** 12 NYCRR 324.2 12 NYCRR 324.3 (Variances)
30	Compliance with ***MTGs***: The exacerbation treatment (exception to variance requirement for continued treatment) information was incomplete or invalid.	C-8.1B	P30	Payer uses **CARC P30** to deny payment of a bill when exacerbation treatments exceeded the ***MTGs*** (incomplete/invalid documentation).	12 NYCRR 324.2 (f) ***Neck Injury MTGs*** D.11.d.i. ***Mid and Low Back Injury MTGs*** D.10.a.i.

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31	Compliance with ***MTGs***: The exacerbation treatment (exception to variance requirement for continued treatment) exceeded what is allowed in the guidelines.	C-8.1B	P31	Payer uses **CARC P31** to deny payment of a bill when exacerbation treatments exceeded the ***MTGs*** (exceeds number/frequency approved/allowed within time period without support documentation).	12 NYCRR 324.2 (f) ***Neck Injury MTGs*** D.11.d.i. ***Mid and Low Back Injury MTGs*** D.10.a.i.
32	The amount of the bill is excessive or not in accordance with pertinent ***Fee Schedule.***	C-8.4	P12	Payer uses **CARC P12** to object to payment of a bill when the bill (line or claim level) is excessive.	WCL § 13(a) ***Fee Schedule***, incorporated by reference in 12 NYCRR 329-1.3
33	The amount of the bill has not been properly pro-rated or apportioned between providers.	C-8.4	B20	Payer uses **CARC B20** to object to payment of a bill when the injured worker 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."
34	The bill uses improper CPT codes.	C-8.4	P13 plus RARC M51	Payer uses **CARC P13** to object to payment of a bill when the bill (line level) has a non-compliant CPT code or a different CPT code is more appropriate. Payer should also use **RARC M51**.	***Fee Schedule***

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35	The bill is not in accordance with a ***Fee Schedule*** "Ground Rule" limitation.	C-8.4	P13 plus RARC N130	Payer uses **CARC P13** to deny payment of a bill when the bill is not in accordance with a ***Fee Schedule*** "Ground Rule" limitation (for example: incorrect modifier used). Payer should also use **RARC N130**. *Please note: This CARC code cannot be used when raising objections related to Ground Rules or CPT codes addressed in or subject to Relative Value Units (RVU) limitations.*	***Fee Schedule***
36	The amount of the bill for dental treatment or treatment outside New York State exceeds the community standard.	C-8.4	P5	Payer uses **CARC P5** 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)
37	The treatment is inappropriate for the clinical situation.	C-8.4	150	Payer uses **CARC 150** to deny payment of a bill when treatment provided was inappropriate for the injury sustained.	***Fee Schedule***
38	The treatment involves concurrent or overlapping services.	C-8.4	59	Payer uses **CARC 59** to deny payment of a bill when treatment involves concurrent or overlapping services (see the medical fee schedule "General Ground Rule" #6).	***Fee Schedule***
39	The treatment is duplicative, excessive, or rendered too frequently.	C-8.4	151	Payer uses **CARC 151** to deny payment of a bill when treatment is duplicative, excessive, or rendered too frequently	***Fee Schedule***
40	The treatment involves unnecessary or excessive hospitalization.	C-8.4	151	Payer uses **CARC 151** to deny payment of a bill when treatment involves unnecessary or excessive hospitalization.	***Fee Schedule***
41	The treatment involves a provider treating outside their scope of practice.	C-8.4	185	Payer uses **CARC 185** to deny payment of a bill when treatment involves a provider treating outside scope of practice (see NYS Education Law).	***Fee Schedule*** NYS Education Law Article 131 Section 6521

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The codes below should be used in conjunction with any applicable codes previously listed, and an objection ***Form C-8.1B*** or ***Form C-8.4*** should be submitted with an EOB containing all the associated CARC/RARC codes. If any of the below scenarios are the only reason for non-payment of a medical bill, an objection ***Form C-8.1B*** or ***Form C-8.4*** is not required but the CARC/RARC codes should be included on the EOB.					
42	Amount of bill exceeds the relative value units for evaluation and services modalities as set forth in the applicable medical fee schedule.	Non-reportable	P13 plus RARC N853	Payer uses **CARC P13** to reduce the amount of the bill to 12, 15 or 18 relative value units for evaluation services and modalities, as set forth in the applicable medical fee schedule Payer should also use **RARC N853**.	***Fee Schedule***
43	Amount of bill reduced pursuant to contractual agreement.	Non-reportable	P24	Payer uses **CARC P24** to reduce the amount of the bill when it is not in accordance with the contracted fee from a NYS WC-certified PPO agreement or other contractual agreement with the provider.	12 NYCRR 325-8
44	The provider's federal taxpayer identification number is not on file.	Non-reportable	252 plus RARC N836	Payer uses **CARC 252** plus **RARC N836** to report that payment is withheld pending receipt of the provider's federal taxpayer identification number on the ***Request for Taxpayer Identification Number and Certification (Form W-9)***.	
45	Payment adjusted due to a resolved apportionment.	Non-reportable	P32	Payer uses **CARC P32** when reducing the payment to a provider as a result of a resolved apportionment of the liability among other injuries.	WCL § 10 WCL § 44

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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 Board, visit **wcb.ny.gov**. Sign up for Board notifications at **wcb.ny.gov/notify**.