Louisiana Department of Health
Informational Bulletin 24-28
August 28, 2024

Appropriate Use of CARC/RARC Codes in Claims Adjudication

Managed care organizations (MCOs) are reminded to utilize the most specific and appropriate Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) when adjudicating claims.

Accurate and precise CARC/RARC code usage is critical for effective communication between payers and providers, facilitating streamlined claim processing, reducing denials, and promoting transparency throughout the revenue cycle.

Key Points

Specificity: MCOs should always select the most specific CARC/RARC code available that accurately reflects the reason for the claim adjustment, and avoid using generic or broad codes when more detailed options exist.

- **Consistency:** Consistency in CARC/RARC code application across similar claim scenarios will help providers better understand the adjudication processes and adapt their billing practices accordingly.
- **Updates:** Claims processing systems should be aligned with the latest standards, including updates or modifications to CARC/RARC code sets.
- **Resources:** Utilize available resources, such as code lookup tools and industry guidelines, to ensure accurate code selection and interpretation.

Provider Benefits of Standardized CARC/RARC Usage:

- **Improved provider communication:** Clearer communication regarding claim adjudication, leading to fewer inquiries and disputes.
- **Reduced claim denials:** Providers can proactively address issues and submit cleaner claims.
- **Enhanced efficiency:** Streamlined claim processing and faster reimbursement for providers.

- **Data analytics:** More granular data for identifying trends, improving processes, and optimizing payment accuracy.

MCO Action Required

MCOs are directed to review their current CARC/RARC usage practices and take necessary steps to ensure adherence to the principles outlined in this bulletin by consistently using the most specific CARC/RARC code available that accurately reflects the reason for the claim adjustment or denial.

One example might be a situation in which a claim is denied because the provider is not a participating provider, or "NON PAR." In cases like this, often the broadly defined CARC 299 code (the billing provider is not eligible to receive payment for the service billed) is used when the more specific CARC 147 (provider contracted/negotiated rate expired or not on file) is a better choice. This would be more appropriate because it provides specific information about why the provider is not eligible to receive payment and allows the provider to make better determinations concerning what actions might be taken to resolve the issue.

Your cooperation is appreciated in promoting standardized CARC/RARC code utilization, which will ultimately benefit both payers and providers by fostering a more transparent and efficient healthcare claims process.