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Denial Patterns & Root Causes

A practice-by-practice look at where revenue leaks out of the claim cycle, what's actually driving the denial, and where to look first on the EOB.

Mindy Corbett, CSPO, CPC, CPB, CPPM
Founder • Revenue Optimization & Intelligence

roithatworks.com

What this is

Revenue leaks look different depending on what the practice actually does. A family medicine clinic and a radiology group can both be running clean operations and still see wildly different denial rates because their payer mix, documentation burden, and coding complexity aren't comparable. That's the point of this guide: give you a realistic band for your specialty and the two or three rationales that explain almost all of it.

Part 1 is the practice-type profile table. Part 2 is a field guide to the 15 CARCs that show up most often on real 835 remits. Both parts link directly into the EDI Lab on roithatworks.com so you can cross-reference a specific CARC or RARC the same day you see it on a remit.

How to use this document

- Find your profile. Use the practice-type table on pages 3–4. If you sit between two profiles (e.g., an internal medicine group with some procedural work), read both.
- Compare your rate to the band. If you're inside the band, your operation is average for your specialty. If you're above it, the primary and secondary rationale columns tell you where to look first.
- Match the CARC. When you pull a recent 835, check the top denial codes against the top-15 table on pages 5–7. Each entry links to a deeper write-up in the EDI Lab.
- Then move to the Playbooks. The companion document, Appeal Strategy Playbooks, walks through how to actually appeal the denials this guide helps you classify.

19	22	15	5–20%
Practice types profiled	Distinct denial profiles	Top CARCs decoded	Realistic denial band

A note on the data

The rate bands reflect a sample of roughly 260 U.S. practices stratified by specialty, crossed against industry benchmarks from MGMA, HFMA, Change Healthcare, and AHIMA. The ranges are directional. A single practice inside a specialty can sit cleanly above or below the band depending on payer mix and state regulations. Use this as a starting point, not a verdict.

Part 1. Practice-type profiles

The table below is the realistic denial-rate band for each practice type, plus the primary and secondary rationale that explains most of the denials inside that band. A few specialties show up multiple times because the service mix legitimately produces different denial patterns. For example, an internal medicine group doing mostly primary care has a very different denial profile than one running a busy procedure clinic.

Practice type	Denial rate	Primary rationale	Secondary rationale
Anesthesiology	10-15%	time units	modifier errors / bundling
Behavioral Health	15-18%	behavioral health payer rules	coverage variance
Chiropractor	10-15%	complex diagnosis codes	lengthy authorizations
Emergency Medicine	12-18%	retrospective documentation	incomplete intake
Family Practice	5-10%	front-end eligibility	coding mistakes
Gastroenterology	10-16%	procedure-based coding	prior-auth gaps
Internal Medicine, primary care	8-14%	volume-driven documentation variability	coding
Internal Medicine, procedure-heavy	10-16%	procedure-based coding	prior-auth gaps
Internal Medicine, high-acuity	12-20%	complex coding	high-$ procedure scrutiny
Neurology	10-15%	complex diagnosis codes	lengthy authorizations
Occupational Therapy	8-12%	therapy caps	functional-limitation documentation
Orthopaedic Surgery	12-15%	prior auth	implant/device coding
Pain Management	12-18%	controlled-substance audits	medical necessity
Pathology	10-14%	technical/professional split	medical necessity

Practice type	Denial rate	Primary rationale	Secondary rationale
Physical Medicine and Rehabilitation, therapy	10-15%	therapy caps	medical necessity documentation
Physical Medicine and Rehabilitation, procedural	12-18%	procedural medical necessity	prior-auth gaps
Physical Therapy, outpatient	8-12%	therapy caps	functional-limitation documentation
Physical Therapy, diagnosis-coded	10-15%	complex diagnosis codes	lengthy authorizations
Podiatry	10-14%	LCD compliance	custom-orthotic coding
Psychiatry and Neurology	10-15%	complex diagnosis codes	lengthy authorizations
Radiology	15-20%	prior auth	medical necessity (highest-risk specialty)
Surgery, general	10-13%	missing auths	bundled-code errors

< 10% normal 10 to 13% watch 14 to 16% elevated 17%+ high-risk

Reading the bands

Rate bands reflect service mix, not competence. A radiology group sitting at 18% is not doing a worse job than a family practice at 8%. Those numbers are normal for each specialty. The useful signal is where you sit within your band, and which of the two rationales is hitting you hardest.

Part 2. The top 15 CARCs you'll actually see

Claim Adjustment Reason Codes (CARCs) are the numeric codes payers attach to every adjustment on an 835 remittance. There are over 300 of them, but in practice about 15 account for the overwhelming majority of real denials. Each entry below includes what the code means, what's usually really happening, and a direct link into the EDI Lab for the deeper write-up.

CARC 16 Claim/service lacks information or has submission/billing error(s).

What's usually happening: Almost always a missing or mismatched data element: a required modifier, NPI, taxonomy code, or referring provider. Check the paired RARC and the group code (see the Root Cause Worksheet) for the specific field.

SEEN MOST IN: Family Practice, Internal Medicine, General Surgery • **Open in EDI Lab →**

CARC 50 Non-covered services because not deemed a medical necessity.

What's usually happening: LCD or NCD is not being met on the claim. The diagnosis code supporting necessity is either missing or wrong. Review the documentation against the applicable LCD before appealing.

SEEN MOST IN: Radiology, Pain Management, PM&R • **Open in EDI Lab →**

CARC 96 Non-covered charge(s).

What's usually happening: Often a plan-specific exclusion or a service billed outside the patient's benefit category. Check eligibility response and benefit details.

SEEN MOST IN: Behavioral Health, Chiropractor • **Open in EDI Lab →**

CARC 97 Benefit for this service is included in payment/allowance for another service.

What's usually happening: Bundling. A separate CPT was billed that the payer considers part of another code billed on the same Date of Service (DOS). Check the NCCI Procedure-to-Procedure edits tool to confirm the edit. Modifier 59 or X{EPSU} may apply only when the documentation supports a distinct service.

SEEN MOST IN: Orthopaedic Surgery, Anesthesiology • **Open in EDI Lab →**

CARC 109 Claim/service not covered by this payer/contractor.

What's usually happening: Wrong payer on file, or the claim should have gone to a secondary or primary carrier first. Rebill to the correct payer.

SEEN MOST IN: All specialties • **Open in EDI Lab →**

CARC 151 Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

What's usually happening: Frequency edit: too many units, too many visits in a window, or a stale auth covering fewer sessions than billed.

SEEN MOST IN: Physical Therapy, Occupational Therapy, PM&R therapy • Open in EDI Lab →

CARC 197 Precertification/authorization/notification/pre-treatment absent.

What's usually happening: No auth on file, auth expired, or auth number not attached to the claim. This is the biggest single auth-related denial in the book.

SEEN MOST IN: Radiology, Orthopaedic, Pain Management • Open in EDI Lab →

CARC 198 Precertification/authorization exceeded.

What's usually happening: Auth existed but covered fewer units or a shorter date range than what was billed.

SEEN MOST IN: Physical Therapy, Occupational Therapy, PM&R therapy • Open in EDI Lab →

CARC 204 This service/equipment/drug is not covered under the patient's current benefit plan.

What's usually happening: Benefit exclusion, not a coding fix. Confirm eligibility, then move to patient responsibility or appeal on medical necessity if the documentation supports it.

SEEN MOST IN: Chiropractor, PM&R, Podiatry • Open in EDI Lab →

CARC 206 National Provider Identifier, missing.

What's usually happening: Required NPI (billing, rendering, or referring) was not on the claim. Common after staffing changes.

SEEN MOST IN: All specialties • Open in EDI Lab →

CARC 208 National Provider Identifier, not matched.

What's usually happening: NPI on the claim does not match the one on file with the payer, or the NPI and taxonomy combination is wrong. This is where the provider taxonomy code itself becomes a denial driver.

SEEN MOST IN: All specialties • Open in EDI Lab →

CARC 252 An attachment/other documentation is required to adjudicate this claim/service.

What's usually happening: The payer needs records: the operative note, therapy evaluation, or imaging report. Send the attachment via the payer's preferred method (fax, portal, or a 275 transaction, which is the HIPAA-standard electronic format for sending clinical attachments with a claim).

SEEN MOST IN: Pathology, Radiology, Orthopaedic • Open in EDI Lab →

CARC 29 The time limit for filing has expired.

What's usually happening: Be honest with yourself first. If the claim was actually submitted after the payer's filing window, this is not appealable. Pursue it as a write-off and fix the process. An appeal is only viable when you have proof of timely submission: a clearinghouse acceptance report (the 277CA, which is the electronic acknowledgement a clearinghouse or payer returns confirming a claim was received) or a dated payer acknowledgement. Prevention is where this denial is solved: daily clearinghouse rejection work queues, a weekly aged-claims report pulled inside each payer's window, and a written follow-up cadence on unpaid claims at day 21/35/49 so nothing quietly crosses the filing deadline.

SEEN MOST IN: All specialties • **Open in EDI Lab →**

CARC 18 Exact duplicate claim/service.

What's usually happening: The claim matches one already on file. Confirm the original adjudication. If it was wrongly denied, appeal the original rather than resubmitting.

SEEN MOST IN: All specialties • **Open in EDI Lab →**

CARC 234 This procedure is not paid separately.

What's usually happening: Another bundling flavor: global surgical package, incident-to rules, or a code that is inclusive by NCCI edit. Modifier review required.

SEEN MOST IN: Orthopaedic, General Surgery, OB/GYN • **Open in EDI Lab →**

One more CARC worth watching

CARC 45 (charge exceeds fee schedule) is technically an adjustment, not a denial. But if you see it on codes that should be at-par, it usually means your fee schedule or contract is out of date. Flag it for contract review, not appeal.

Root cause worksheet

Before you appeal a denial, run through this worksheet. Most practices appeal the symptom and miss the system that keeps generating the same denial next month.

#	Question	What to look for
1	What CARC, RARC, and Group Code are on the 835?	All three together tell the real story. The Group Code (CO = Contractual Obligation, PR = Patient Responsibility, OA = Other Adjustment, PI = Payer Initiated) tells you who owns the dollars. CO means the provider writes it off. PR means it shifts to the patient. OA and PI usually mean more payer work or an adjustment reversal is needed. The CARC and RARC pair tell you why. A CARC 16 with RARC N382 is a missing patient ID. A CARC 16 with RARC M76 is a missing diagnosis. Different fixes for each combination.
2	Is this a one-off or a pattern?	Pull 90 days of 835s. If this CARC is in your top 5 by frequency or dollar, it is a process issue, not a claim issue. Systemic patterns belong in the Revenue Integrity Master Audit (available at roithatworks.com) so the fix gets owned at the operations level, not the claim level.
3	Where in the workflow did it originate?	Front desk eligibility, provider documentation, coder abstraction, biller submission, or payer side? Each has a different owner.
4	Is the contract or fee schedule current?	A surprising number of 'denials' are adjustments against stale contracts. Pull your payer agreement and compare.
5	What would prevent the next one?	A specific, observable change: a new eligibility check, a coding rule in the EMR, a front-desk script, or a payer rep escalation.

The companion document

Once you have classified the denial and found the pattern, the Appeal Strategy Playbooks document walks through the four appeal types you will actually write (authorization, timely filing, medical necessity, and bundling) with real templates you can adapt. Download at roithatworks.com/denials-appeals-library.

ABOUT THE AUTHOR

Mindy Corbett

CSPO • CPC • CPB • CPPM

Founder • Revenue Optimization & Intelligence

Mindy built Revenue Optimization & Intelligence to help specialty practices and billing companies stop losing revenue to denials that were preventable on the front end. Credentials: Certified Scrum Product Owner, Certified Professional Coder, Certified Professional Biller, and Certified Physician Practice Manager. Her public work focuses on denial prevention, appeal strategy, payer rule drift, and the operational systems that keep clean claims clean.

Explore the EDI Lab →	Live CARC / RARC / CAGC lookups.	www.roithatworks.com/edi-lab.html
Read the newsletter →	Weekly denial patterns & payer rule changes.	www.roithatworks.com/newsletter.html
Connect on LinkedIn →	Daily posts on denials, appeals, and RCM.	www.linkedin.com/in/mindycorbett
Get the Appeal Playbooks →	The companion document to this guide.	www.roithatworks.com/denials-appeals-library.html