

# Codes, Policies & Workflow Reference

*Quick-Access Guide for All Payer Types*

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## Table of Contents

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1. Key Code Sets Overview
2. CARC / RARC Reference Table
3. Place of Service (POS) Codes
4. Modifier Reference
5. Timely Filing Reference by Payer Type
6. Authorization Quick Reference
7. Payer-Specific Policy Sources
8. RCM Workflow Decision Trees

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# 1. Key Code Sets Overview

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Code Set	Purpose	Maintained By	Used On
ICD-10-CM	Diagnosis coding	CMS / CDC	All claim types
ICD-10-PCS	Inpatient procedure coding	CMS	UB-04 (inpatient)
CPT (HCPCS I)	Outpatient/physician procedures	AMA	CMS-1500 / 837P
HCPCS II	DME, drugs, supplies, services	CMS	All claim types
CDT	Dental procedure codes	ADA	Dental claims
DRG (MS-DRG)	Inpatient payment grouping	CMS	UB-04 (IP)
Revenue Codes	Hospital service line classification	NUBC	UB-04
NDC	Drug identification	FDA	Pharmacy/drug claims

## 2. CARC / RARC Reference Table

The following are the most frequently encountered CARC codes across all payer types. For the complete current list, reference [www.wpc-edi.com](http://www.wpc-edi.com).

CARC	Description	Recommended Action
1	Deductible amount	Patient responsibility — bill patient
2	Coinsurance amount	Patient responsibility — bill patient
3	Co-payment amount	Patient responsibility — bill patient
4	Service inconsistent with modifier	Review modifier; recode if needed
16	Claim lacks required info	Correct and resubmit
18	Duplicate claim	Verify; void if true duplicate
22	Coordination of benefits	Coordinate with primary payer
27	Expenses incurred after coverage terminated	Verify eligibility at DOS
29	Timely filing limit exceeded	Submit proof of timely filing
45	Charges exceed fee schedule/contracted amount	Contractual adjustment; no action
49	Non-covered service	Bill patient if ABN on file
50	Not medically necessary	Appeal with clinical documentation
57	Prior coverage decision	Verify auth and resubmit
96	Non-covered charge	Contractual — adjust off
97	Bundled into another service	Review unbundling rules
119	Benefit maximum exceeded	Bill patient per EOB
167	Benefit not covered for this DOS	Verify plan year and eligibility
197	Auth absent	Retroactive auth or appeal
242	Services not provided by network provider	Verify network status

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### 3. Place of Service (POS) Codes

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Code	Setting	Common Use
11	Office	Physician office visits
21	Inpatient Hospital	Acute inpatient stays
22	On-Campus Outpatient Hospital	HOPDs, outpatient surgery
23	Emergency Room	ED visits
24	Ambulatory Surgical Center	ASC procedures
31	Skilled Nursing Facility	SNF stays
32	Nursing Facility	Long-term care
49	Independent Clinic	Freestanding clinics
71	State/Local Public Health Clinic	Public health services
02	Telehealth (Provider Site)	Telehealth services (post-2020)
10	Telehealth (Patient Home)	Patient-site telehealth (post-2020)

## 4. Modifier Reference

Modifiers indicate that a service has been altered but not changed in definition. Incorrect modifier use is a leading cause of coding denials.

Modifier	Description	Key Note
25	Significant, separately identifiable E&M; service same day as procedure	High scrutiny — must be supported by separate documentation
26	Professional component	Use when billing pro fee only (no TC)
TC	Technical component	Use when billing facility/equipment only
51	Multiple procedures	Apply to secondary procedures; primary gets no modifier
59	Distinct procedural service	Bypass bundling edits when truly separate; document carefully
76	Repeat procedure by same physician	Use when procedure repeated on same DOS
GT	Via interactive audio/video	Telehealth services (legacy)
95	Synchronous telemedicine service	Real-time audio/video telehealth
GQ	Via asynchronous telehealth	Store-and-forward telehealth
LT/RT	Left/Right side	Bilateral procedures; required by many payers
KX	Requirements specified in policy met	Medicare durable medical equipment

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## 5. Timely Filing Reference by Payer Type

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■ **Important: Timely filing limits are subject to change. Always verify current limits in your payer contract or provider manual before submitting claims or appeals.**

Payer Type	Initial Filing Limit	Appeal Timely Filing
Medicare FFS	12 months from DOS	120 days from denial date
Medicaid (General)	90–365 days (state-specific)	Varies by state
Medicare Advantage	Payer-specific (typically 90–180 days)	60 days from denial
Commercial PPO (typical)	90–180 days	30–180 days post-denial
Managed Medicaid (MCO)	90–365 days (state/plan specific)	Varies
TRICARE	12 months from DOS	90 days from EOB
Workers' Compensation	Varies by state	Varies by state
CHIP	Varies by state	Varies by state

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## 6. Authorization Quick Reference

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Payer Type	Auth Scope	Policy Source
Medicare FFS	Limited; primarily DME, HH, select procedures	CMS, MACs, LCD/NCD
Medicare Advantage	Plan-specific; often broader than FFS	Plan medical policy
Medicaid	Highly variable by state and service type	State Medicaid manual
Commercial HMO	Comprehensive; PCP referral often required	Plan provider manual
Commercial PPO	Selective; high-cost procedures and inpatient	Plan provider manual
Managed Medicaid	Plan-specific; follows state guidelines	MCO provider portal

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## 7. Payer-Specific Policy Sources

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Staying current on payer policies is a core competency for revenue cycle teams. Bookmark these sources and assign monitoring responsibilities.

**Medicare FFS:** CMS.gov — Medicare Coverage Database (LCD/NCD), MLN Matters, Fee Schedule files

**Medicare Advantage:** Individual plan provider portals + CMS Medicare Advantage & Part D (MAPD) guidance

**Medicaid:** State Medicaid agency websites — provider bulletins, managed care plan portals

**Commercial:** Plan provider portals — medical policy libraries, clinical guidelines, fee schedules

**TRICARE:** [tricare.mil](http://tricare.mil) — provider section, policy manual, coverage determinations

**AMA/CMS Joint:** CPT code updates (AMA), HCPCS updates (CMS) — released annually October/November

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## 8. RCM Workflow Decision Trees

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### Denial Receipt Decision Tree

- **Denial received via 835/ERA or paper EOB**

- ◆ **Is denial reason valid? (Correct CARC identified)**

- If NO — Contact payer for clarification or resubmit corrected claim

- If YES — Categorize by root cause domain (Admin / Clinical / Coding / Technical)

- ◆ **Is denial within appeal window?**

- If NO — Escalate to supervisor; evaluate write-off or OON options

- If YES — Assign to appropriate specialist with appeal deadline

- Submit appeal with supporting documentation

- Track response; follow up at 30 days

- **Overtake? Record as recovered revenue. Upheld? Evaluate next level or write-off.**

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