CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13621	**Date: February 11, 2026**
	Change Request 14318

SUBJECT: Medicare Administrative Contractors (MACs) Part B, the Multi- Carrier System (MCS) and Durable Medicare Equipment (DME) MACs Updates on Processing Medicare Secondary Payer (MSP) Claims Containing Certain Claim Adjustment Reason Codes (CARCs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct Part B MACs and Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) on how to process MSP claims containing certain CARCs as identified in this CR. Part B and DME MACs process MSP claims containing CARCs based on previous CMS instructions. Over the years, many of these CARCs were processed through automation, denied, or suspended for manual review.

However, after recent discussions held with the Part B MACs, several CARCs can now be processed through automation without manual intervention while others will continue to be suspended. The change request identifies those CARCs codes that will be processed through automation and those that will be suspended for manual review or even denied.

EFFECTIVE DATE: July 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct Part B MACs and Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) on how to process MSP claims containing certain CARCs as identified in this CR. Part B and DME MACs process MSP claims containing CARCs based on previous CMS instructions. Over the years, many of these CARCs were processed through automation, denied, or suspended for manual review.

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II. GENERAL INFORMATION

A. Background: The changes herein addressed are necessary to ensure Medicare's compliance with the Health Insurance Portability Act (HIPAA) transaction and code set requirements and to ensure that MSP claims are properly calculated by the Medicare contractors and their associated shared systems using payment information derived from the incoming 837 Professional claim. MSP policy also dictates what the shared systems and contractors must take into consideration when processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the Claim Adjustment Segment (CAS) on the 835 Electronic Remittance Advice (ERA) or paper remittance. The provider must take the CAS segment adjustments, as found on the 835 and report these adjustments on the 837 unchanged, when sending the claim to Medicare for secondary payment. Part B and DME MACs must use CAS segment adjustment amounts in determining MSP payment on MSP claims using CARCs found in the CAS segment.

B. Policy: Part B and DME MACs and associated shared systems must utilize the CARCs adjustments on the 837 when adjudicating MSP claims.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14318.1	The Part B and DME MACs and designated shared systems		X		X		X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	shall update their processes and tables to process the below CARCs found on MSP claims as discussed in the previous MSP calls.									
14318.2	MCS shall update the following CARCs on the H99TSTND to include an MSP Action Code of 'D' (Deny): 5, 6, 7, 8, 9,12,18,53,97, 107, 116, 148, 171, 183, 185, 193, 224, 250, 251, 252, 285, 286, 300, 301, 304, 305, B12, B13, P30, P7						X			
14318.2.1	DME MACs shall set up the following CARCs on the VMAP/4C/ANSILIST detail screen with the value of "N" in the MSP CAS field, which denotes that they deny MSP services when the following CARCs are found on MSP claims: 5, 6, 7, 8, 9, 12, 18, 53, 97, 107, 116, 148, 171, 183, 185, 193, 224, 250, 251, 252, 285, 286, 300, 301, 304, 305, B12, B13, P30, P7				X					
14318.3	Part B MACs and designated shared system shall accept and process for MSP services when the following CARCs are found on MSP claims. Note that these claims may still be suspended or denied for reasons other than the listed CARCs: 23, 33, 40, 109, 172, 178, B20, B22		X				X			
14318.3.1	MCS shall update the CARCs in above BR 3 on the H99TSTND to remove the						X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	MSP Action Code.									
14318.3.2	DME MACs shall set up the following CARCs on the VMAP/4C/ANSILIST detail screen with the value of "S" in the MSP CAS field, which denotes that they deny MSP services when the following CARCs are found on MSP claims: 23, 33, 40, 109, 172, 178, B20, B22				X					
14318.4	Part B MACs and designated shared system shall suspend MSP claims for manual review for MSP services when the following CARCs are found on MSP claims. Note that these claims may still be denied by the claims processing system: 26, 31, 32, 166, 200, 242, 256, P1		X				X			
14318.4.1	MCS shall update the CARCs in above BR 4 on the H99TSTND to include an MSP Action Code of 'S' (Suspend).						X			
14318.4.2	DME MACs shall set up the following CARCs on the VMAP/4C/ANSILIST detail screen with the value of "R" in the MSP CAS field, which denotes that they deny MSP services when the following CARCs are found on MSP claims: 26, 31, 32, 166, 200, 242, 256, P1				X					
14318.5	DME MACs shall add the adjustment amount to the payment amount when CARC				X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	308 is received on an MSP Claim.									
14318.5.1	This Business Requirement is deleted.		X				X			
14318.5.2	DME MACs shall set up the CARC 308 on the VMAP/4C/ANSILIST detail screen with the value of "A" in the MSP CAS field, which denotes that they add the CARC 308 adjustment amount to the paid amount found on MSP claim.				X					
14318.6	Contractors shall be aware that all other CARCs processes and procedures identified in previous CRs, but not mentioned in this CR, are not being updated.		X		X					

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

STANDARD Code	Standard Code Desc1	Standard Code Desc2	Standard End Date	MSP System Action: A/P = Pay - Process without denying. B/D/E/W = Deny S = Suspend	New System action: D = Deny S = Suspend P = Continue to Process	CGS	FC/Novitas	NGS	Noridian	Palmetto/RR	WPS	
B12	SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECOR	DS.	0	S	D - All agreed							
B13	PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MA	Y HAVE BEEN PROVIDED IN A	0	S	D - All agreed							
107	THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT ID	ENTIFIED ON THIS CLAIM.	0	S	D - All agreed							
116	THE ADVANCE INDEMNIFICATION NOTICE SIGNED BY THE P	ATIENT DID NOT COMPLY WIT	0	S	D - All agreed	Pay - Agree to deny	Denies	deny	deny	Pay - Agree to deny	Deny	
12	THE DIAGNOSIS IS INCONSISTENT WITH THE PROVIDER TY	PE. USAGE: REFER TO THE	0	S	D - All agreed	Deny	deny	deny	deny	ok to deny	deny	
148	INFORMATION FROM ANOTHER PROVIDER WAS NOT PROVIDED	OR WAS INSUFFICIENT/INCOM	0	S	D - All agreed							
171	PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TY	PE OF PROVIDER IN THIS TY	0	S	D - All agreed	pay	deny	deny	pay	deny	pay	
18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP	CODE OA EXCEPT WHERE STA	0	S	D - All agreed							
183	THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER TH	E SERVICE BILLED.	0	S	D - All agreed	pay	deny	deny	pay	pay	pay	
185	**THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM**	**THE SERVICE BILLED.**	**0**	**S**	D - All agreed	**pay**	**deny**	**deny**	**pay**	**deny**	**pay**	
193	ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPO	N REVIEW, IT WAS DETERMIN	0	S	D - All agreed							
224	PATIENT IDENTIFICATION COMPROMISED BY IDENTITY	THEFT. IDENTITY VERIFICAT	0	S	D - All agreed	Deny	suspend - review.	deny	deny	pay	suspend and review	
97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PA	YMENT/ALLOWANCE FOR ANOTH	0	S	D - All agreed		W	deny	Agree to deny	DENY	Not in attendence	deny
53	Services by an immediate relative or a member of t	he same household are not	0	P	D - All Agreed	Deny	P	deny D445	Pay	DENY	pay	
5	THE PROCEDURE CODE/TYPE OF BILL IS INCONSISTENT WI	TH THE PLACE OF SERVICE.	0	S	D - all agreed. Provider must submit correctly to Primary Insurance.	deny	Deny	deny	Pay but would be ok to deny	RESEARCH PROCEDURE CODE - If Medicare allows based on place of servcie - pay If Medicare does not allow based on place of service - the system shouuld have auto-denied. If not denied, Palmetto would manually deny	Not in attendence	If same for Medicare, leave the denial, if no denial then pay
6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH TH	E PATIENT'S AGE.	0	S	D - all agreed. Provider must submit correctly to Primary Insurance.	deny	Deny	deny	Pay but would be ok to deny	RESEARCH PROCEDURE CODE - If Medicare allows based on beneficiary age - pay If Medicare does not allow based on beneficiary age the system shouuld have auto-denied. If not denied, Palmetto would manually deny	Not in attendence	If same for Medicare, leave the denial, if no denial then pay
7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH TH	E PATIENT'S GENDER.	0	S	D - all agreed. Provider must submit correctly to Primary Insurance.	deny	Deny		Pay but would be ok to deny	RESEARCH PROCEDURE CODE - If Medicare allows based on beneficiary Sex - pay If Medicare does not allow based on beneficiary sex the system shouuld have auto-denied. If not denied, Palmetto would manually deny	Not in attendence	If same for Medicare, leave the denial, if no denial then pay
8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVID	ER TYPE/SPECIALTY (TAXONO	0	S	D - all agreed. Provider must submit correctly to Primary Insurance.	deny	Deny	deny	Pay but would be ok to deny	PAY	Not in attendence	If same for Medicare, leave the denial, if no denial then pay
9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S A	GE. USAGE: REFER TO THE 8	0	S	D - all agreed. Provider must submit correctly to Primary Insurance.	deny	Currently suspend and review	deny	Pay but would be ok to deny	PAY	Not in attendence	If same for Medicare, leave the denial, if no denial then pay
P30	PAYMENT DENIED FOR EXACERBATION WHEN SUPPORTING DO	CUMENTATION WAS NOT COMPL	0		D-All agree	suspend and review	L=Liability		Pay	CMS INPUT	CMS Input	
P7	THE APPLICABLE FEE SCHEDULE/FEE DATABASE DOES NOT	CONTAIN THE BILLED CODE.	0		D-All agree	suspend and review	L=Liability	Need RARC or deny	Pay	CMS INPUT	CMS Input	
250	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIV	ED WAS THE INCORRECT	0		Deny - All agree	suspend and review	A=Pay		Pay	DENY	deny	
251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIV	ED WAS INCOMPLETE OR DEFI	0		Deny - All agree	suspend and review	A=Pay		Pay	DENY	deny	
252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO	ADJUDICATE THIS CLAIM/SER	0		Deny - All agree	suspend and review	A=Pay	Deny D928 if no primary payment	Pay	DENY	deny	
285	APPEAL PROCEDURES NOT FOLLOWED.		0		Deny - All agree	suspend and review	D=Deny		Pay	DENY	pay	
286	APPEAL TIME LIMITS NOT MET.		0		Deny - All agree	suspend and review	D=Deny		Pay	DENY	pay	
300	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS	NOT AVAILABLE UNDER THIS	0		Deny - All agree	suspend and review	P=Pay		Pay	DENY	Pay	
304	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS N	OT AVAILABLE UNDER THIS P	0		Deny - All agree	suspend and review	D=Deny		Pay	DENY	Pay	
305	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS N	OT AVAILABLE UNDER THIS P	0		Deny - All agree	suspend and review	D=Deny		Pay	DENY	Pay	
109	Claim not covered by this payer/contractor. You mu	st send the claim to the	0	S	P - All agreed	CGS - Denies	Pays	NGS - Review and Denies/Pay/ECRS:	Hold Claim until ECRS, if no response Pay	Pay	Hold Claim until ECRS, if no response Pay	
172	PAYMENT IS ADJUSTED WHEN PERFORMED/BILLED BY A PRO	VIDER OF THIS SPECIALTY	0	S	P - All agreed	pay	Pays	pay	pay	pay	pay	
178	PATIENT HAS NOT MET THE REQUIRED SPEND DOWN REQUIR	EMENTS.	0	S	P - All agreed		deny	deny	pay	pay	pay	
23	THE IMPACT OF PRIOR PAYER(S) ADJUDICATION INCLUDIN	G PAYMENTS AND/OR ADJUSTM	0	S	P - All agreed	Deny - ok to Pay	pay as prime	pay	pay	pay	pay	
33	INSURED HAS NO DEPENDENT COVERAGE.		0	S	P - All agreed	suspend and review	Pay	suspend and review	Pay but would be ok to deny	suspend and review	Not in attendence	send ECRS is record is open; if not pay prime
40	CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENT/UR	GENT CARE. USAGE: REFER T	0	S	P - All agreed	pay	pay	suspend and review	Pay but would be ok to deny	suspend and review - PAY	Not in attendence	pay
B20	PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED	BY ANOTHER PROVIDER.	0		P-All Agreed	suspend and review	D=Deny	pay	Pay	LEAVE BLANK	pay	
B22	THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.		0		P-All Agreed	suspend and review	P=Pay	pay	Pay	LEAVE BLANK	pay	
166	These services were submitted after this payers re	sponsibility for processi	0	P	S - All agreed	pay	while we currently do P for this, questioning because eligibility related. CMS weigh in?	suspend and review	Pay	SUSPEND FOR FURTHER REVIEW	pay	
200	Expenses incurred during lapse in coverage		0	P	S - All agreed	Pay	P	suspend and review	Pay	SUSPEND FOR FURTHER REVIEW	pay	
242	SERVICES NOT PROVIEDED BY NETWORK/PRIMARY CARE PRO	VIDERS.	0	P	S - All agreed		P	suspend and review	Agree to suspend		pay	
256	SERVICES NOT PAYABLE PER MANAGED CARE CONTRACT		0	P	S - All agreed	Deny	P	suspend and review	Suspend like 242	AGREE	pay	
26	Expenses incurred prior to coverage.		0	P	S - All agreed	Pay - may send ECRS	P	suspend and review	Pay	SUSPEND FOR FURTHER REVIEW	pay	
31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.		0	P	S - All agreed	Deny	P	suspend and review	Suspend; review; deny or pay	SUSPEND FOR FURTHER REVIEW	send ECRS is record is open; if not pay prime	
32	OUR RECORDS INDICATE THE PATIENT IS NOT AN ELIGIBL	E DEPENDENT.	0	P	S - All agreed	Deny - ok to Pay	P	pay	Pay	SUSPEND FOR FURTHER REVIEW	send ECRS is record is open; if not pay prime	
P1	STATE-MANDATED REQUIREMENT FOR PROPERTY AND CASUAL	TY, SEE CLAIM PAYMENT REM	0		S-All Agree	suspend and review	L=Liability	Need RARC or deny	Suspend and review	CMS INPUT	CMS Input	