

Mental Health Claim Denial Codes: Cheat Sheet

The 10 claim adjustment reason codes (CARCs) mental health practices see most, what they mean and how to fix them. Meanings are summarized from the official X12 code list; always read the remark codes (RARCs) on the remittance too.

Code	What it means	Common mental health cause	How to fix it
CO-4	The procedure code doesn't match the modifier, or a required modifier is missing.	Telehealth session billed without the modifier the payer requires.	Add the correct modifier and place-of-service code; send a corrected claim.
CO-11	The diagnosis doesn't support the procedure.	A Z-code or a diagnosis the plan doesn't cover listed first.	List the treated mental health diagnosis (F-code) first; resubmit.
CO-16	The claim is missing information or has a billing error.	Missing rendering provider, NPI, authorization number or patient details.	Add the missing data shown in the remark code; resubmit.
CO-18	Exact duplicate of a claim already received.	Claim resent while the first one was still processing.	Check claim status before resending; use a corrected claim (frequency code 7) to change a paid claim.
CO-22	Another payer may be primary (coordination of benefits).	Secondary plan billed as primary.	Update coordination of benefits; bill the primary payer first.
CO-29	The time limit for filing has expired.	Claim sent after the payer's timely filing limit.	Appeal only with proof of timely filing, such as a clearinghouse acceptance report.
CO-50	Not medically necessary according to the payer.	Notes don't show medical necessity, or session frequency exceeds policy.	Appeal with progress notes and the treatment plan that show necessity.
CO-97	Payment is included in another service already paid.	Standalone psychotherapy billed with an E/M on the same day.	Bill the E/M with the psychotherapy add-on (90833, 90836 or 90838) instead.
CO-119	Benefit maximum for the period has been reached.	Annual visit limit used up.	Confirm visits used; request more visits or bill the patient as the contract allows.
CO-197	Required authorization was not obtained.	Session without authorization, or past the authorized number of visits.	Request a retro-authorization if the payer allows it; track visits against each authorization.

Prevention matters more than appeals: verify benefits and authorizations before the first session, match documented time to the CPT code, and work every denial within days.

Need help with denials? See prospecthealthcaresolutions.com/denial-management-solutions/