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# Understanding Dental Claim Payments and Denials

An illustrated beginner guide to CARCs, RARCs, and what to do

**Start here.** On the office's electronic remittance advice (ERA/835) or explanation of payment (EOP), look for adjustment reasons and remarks at the claim or service line. A patient's explanation of benefits (EOB) may summarize these without showing the raw codes. The Code on Dental Procedures and Nomenclature (CDT) identifies the service. Not every adjustment is a denial.

## 1 Read the full payment message

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **SERVICE** | **DOLLARS** | **GROUP** | **CARC** | **RARC** |
| Match CDT line, date, tooth or quadrant. | Check billed, allowed, adjusted, and paid. | See the responsibility category. | Find the general adjustment reason. | Read detail, alerts, and plan text. |

## 2 What each code tells you

| GROUP CODE | CARC | RARC |
|---|---|---|
| Which category carries the adjustment? Read this before considering a patient balance. | Claim Adjustment Reason Code. It gives the general reason payment differs from the billed amount. | Remittance Advice Remark Code. It adds specific detail or communicates a separate processing alert. |
| **CHECK:** CO, PR, OA, or PI. | **CHECK:** Examples: cost sharing or missing documentation. | **CHECK:** Read the full text, not only the number. |

## 3 Know the responsibility categories

| CO | PR | OA | PI |
|---|---|---|---|
| **CONTRACTUAL** | **PATIENT** | **OTHER** | **PAYER REDUCTION** |
| Check provider contract. | Verify before billing. | Investigate the reason. | Review payer decision. |

### A $150 PAYMENT LINE EXAMPLE

| $150 | – $50 | – $20 | = $80 |
|---|---|---|---|
| **BILLED** | **CO–45** | **PR–2** | **PAID** |
| Original charge. | Fee adjustment. | Reported coinsurance. | Plan payment. |

The line balances, but the code alone does not set the bill. Confirm the full remittance, benefits, provider agreement, other coverage, and applicable billing rules.

# Read the codes together

The CARC gives the general reason. The RARC may supply the detail needed to understand it.

## 1 A complete example from an image request

| CO | 252 | N928 |
|---|---|---|
| GROUP CODE | CARC | RARC |
| Contractual obligation category. | Documentation is required. | Bitewing or periapical x-ray issue. |

**Office response:** Confirm which image the plan needs, whether it was linked to the correct claim and received, and what submission or appeal path the plan specifies.

## 2 The same RARC can point to three different actions

N928 identifies the kind of item. The CARC tells what happened to it.

| 250 + N928 | 251 + N928 | 252 + N928 |
|---|---|---|
| Wrong document received; the expected bitewing or periapical x-ray is still missing. | An image was received, but it is incomplete or deficient. | A bitewing or periapical x-ray is needed to adjudicate the claim. |
| CHECK: Find the requested image and check what was sent. | CHECK: Review image quality, date, labels, area, and transmission. | CHECK: Confirm the request and how to send the image. |

**CARCs 250, 251, and 252** require at least one qualifying non-Alert remark code. These are teaching examples; use the actual codes and full plan message on the claim.

## 3 Read an Alert differently

| SUPPLEMENTAL RARC | "ALERT:" RARC |
|---|---|
| Adds explanation to an adjustment already described by a CARC. | Conveys information about processing; it is not tied to a specific adjustment. |
| CHECK: Use it with the CARC and group code. | CHECK: Read and act on the alert separately. |

**N935 Medicaid / QMB Alert**

Patient is no longer identified as Medicaid-eligible or a Qualified Medicare Beneficiary.

CHECK: Verify eligibility and billing restrictions before billing.

**Some CARCs can stand alone; others require a qualifying remark.** If a required remark is missing from the office view, request the complete remittance before deciding what to correct.

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# Common reasons a dental claim pays differently

Selected CARCs and first checks. These examples are not every code; use the live X12 list for the complete, current set.

## COST SHARING AND FEES

### 1 / 2 / 3

Deductible / coinsurance / copayment.

CHECK: Confirm benefit details and any other coverage.

### 45

Charge exceeds fee schedule, maximum allowed amount, or contracted/legislated fee.

CHECK: Compare billed and allowed amounts, network status, and contract.

## CLAIM DATA AND DUPLICATES

### 16

Required claim information is missing or the submission contains an error. It is not the attachment code.

CHECK: Read the qualifying remark for the specific data element.

### 18

Exact duplicate claim or service; X12 generally uses OA.

CHECK: Find the original claim and any prior payment.

## COVERAGE AND BENEFIT RULES

### 96

Noncovered charge.

CHECK: Read the qualifying remark, plan exclusion, and appeal information.

### 97

Payment for this service is included in another service.

CHECK: Check the other line and bundling rule.

### 119

Benefit maximum for the time period or occurrence has been reached.

CHECK: Check the benefit period and paid history.

### 197

Required precertification, authorization, notification, or pretreatment is absent.

CHECK: Verify the plan requirement and records.

## DOCUMENTS AND THE RIGHT BENEFIT PLAN

### 250 / 251 / 252

Wrong document / incomplete document / documentation required.

CHECK: Pair with the RARC to see which item needs attention.

### 254 vs 290

Both concern unavailable dental benefits. 254 tells you to submit to medical; 290 says the claim was forwarded.

CHECK: Check the forwarding status before resubmitting.

**CARC 29** Filing time limit expired. Check the plan deadline, submission and receipt dates, and proof of timely filing before appealing.

# Dental details on the remittance

The code identifies the item to check. The paired CARC and plan message explain what to do about it.

## 1 Dental-relevant RARCs effective in 2026

### N922 Primary care dentist

Missing primary care dentist information.

CHECK: Assignment, enrollment, and identifiers.

### N927 X-ray

Missing / incomplete / invalid x-ray.

CHECK: Image type, date, quality, and delivery.

### N928 Bitewing or PA

Missing / incomplete / invalid bitewing or periapical x-ray.

CHECK: Tooth or area, date, and receipt.

### N929 Photographs

Missing / incomplete / invalid photos.

CHECK: Images, labels, date, and claim link.

### N930 Quadrant

Missing / incomplete / invalid quadrant identifier.

CHECK: Claim line and clinical record.

### N931 Pre/post BW or PA

Missing / incomplete / invalid pre/post bitewing or periapical x-ray.

CHECK: Which timepoint and image is required.

### N932 Pre/post FMX

Missing / incomplete / invalid pre/post full-mouth x-ray.

CHECK: Series, timepoint, and receipt.

### N933 Pre/post photos

Missing / incomplete / invalid pre/post photos.

CHECK: Photo set, timepoint, and labels.

### N934 Full-mouth x-ray

Missing / incomplete / invalid full-mouth x-ray.

CHECK: Series completeness and quality.

### N940 Pre/post x-ray

Missing / incomplete / invalid pre/post x-ray, general.

CHECK: Requested image, timing, and link.

## OTHER REMARKS YOU MAY ENCOUNTER

### N923–N926 Medicare Advantage

Payment-responsibility status on encounter records; not dental attachment codes. Pending is not a final denial.

| N923 | N924 | N925 | N926 |
|---|---|---|---|
| DETERMINED | PENDING | DENIED | PARTIAL |
| Not denied; determination made. | No determination yet; not denied. | No payment responsibility. | No responsibility for some lines. |

CHECK: Review the full record and plan channel.

# Turn the message into the right next step

Use the full remittance, current code descriptions, and the plan's instructions.

## 1 Work through the claim

| | |
|---|---|
| **1 LOCATE**<br>Match patient, claim, date, CDT line, tooth or quadrant, and amount. | **2 DECODE**<br>Read group code, CARC, every RARC, dollars, and plan text. |
| **3 VERIFY**<br>Compare the submission, attachments, benefits, contract, and other coverage. | **4 ACT**<br>Send requested material, correct data, ask for review, or appeal by deadline. |
| **5 DOCUMENT**<br>Save confirmation, claim reference, response, and final reconciliation. | **6 CHECK LIABILITY**<br>Confirm the amount, plan terms, contract, and billing rules before invoicing. |

A CARC or RARC never settles patient liability by itself. Ask: Is there a PR amount? Do benefits and the contract allow collection? Have other coverage and billing restrictions been checked?

## 2 Scan the full, current code lists

**The examples printed here are not all CARCs or RARCs.** X12 maintains the full code lists across health care. Search the CARC page for "dental" to find explicitly dental-specific entries; general codes also apply to dental claims. Check Current versus Deactivated.

| CARCs \| All adjustment reasons | RARCs \| All remark codes |
|---|---|
| Open live X12 list | Open live X12 list |

More help: X12 group codes • ADA guide to reading an EOB

**Questions about a specific claim?** Contact the dental plan using its provider services number, portal, or EOB/EOP instructions. X12 defines the codes; the plan can address claim-specific next steps.

Educational use only. Checked September 23, 2026. Follow the current remittance, benefit and contract documents, and applicable billing and appeal requirements.