CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1267	**Date: JUNE 15, 2007**
	Change Request 5634

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update and Medicare Remit Easy Print (MREP) Enhancement.

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the contractors that a RARC must be used with CARCs 16, 17, 96, 125, and A1. It also instructs ViPs to provide updated MREP software incorporating enhancements approved by CMS.

NEW / REVISED MATERIAL
EFFECTIVE DATE:*July 1, 2007
IMPLEMENTATION DATE: July 2, 2007

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	

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1267	Date: June 15, 2007	Change Request: 5634

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update and Medicare Remit Easy Print (MREP) Enhancement

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that Remittance Advice Remark Codes (RARCs) are required in the remittance advice transaction.

Payers communicate the reason for any adjustment (when the payment differs from the amount billed) using these 2 sets of codes along with a group code. The group codes identify who is financially responsible for the amount that the payer is not reimbursing. Medicare uses the following group codes:

CO Contractual Obligation (Provider is financially responsible)
PR Patient responsibility (Provider can collect the amount from patient)
OA Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
CR Correction (Used with reversal and correction)

The CARC provides an explanation why an amount is being adjusted and the RARC provides supplemental explanation about the adjustment. A RARC can also provide information. Any RARC that has the word "Alert" is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication. The 835 version 004010A1 Implementation Guide (IG) requires CARC if needed but does not require use of RARCs. The CARCs are usually very generic and do not provide enough explanation and as a result manual intervention becomes necessary. In order to make health plans use appropriate RARCs with CARCs where needed, the code committee that maintains the CARC code set recently modified 5 CARCs. These CARCS have been selected because they are: a) very generic; and b) used most frequently. The following 4 CARCs now require use of at least one appropriate RARC: 16, 17, 96, and 125. Additionally CARC A1 also will require at least one RARC effective June 1, 2007.

JSM/TDL 07307 instructed Medicare contractors to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any of the existing RARCs, that is not being used currently, may be appropriate to explain an adjustment. Contractors may start using any of the currently existing RARCs with 16, 17, 96, 125, and A1. The most current list of RARCs is available at:
http://www.wpc-edi.com/codes

The committee that maintains the reason codes has approved a new reason code 204 ("This service/equipment/drug is not covered under the patient's current benefit plan") that became effective on 2/28/07. Contractors may use this new reason code in lieu of reason code 96 and a remark code (e.g., N130) when appropriate. ViPs will add RARC N130 to be used with CARC 96 as a default combination to be reported if no code has been assigned by the contractor and the service is not covered by Medicare.

We are also collecting monthly data on current code usage by contractors and will continue to monitor if a RARC is being used with those 5 CARCs, and take corrective actions if needed.

Medicare Remit Easy Print (MREP) Enhancement

CMS has developed software called Medicare Remit Easy Print (MREP) that gives providers a tool to read and print an electronic remittance advice (RA) in a human readable format. Providers who use the MREP software package, have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claim submission to secondary/tertiary payers for Coordination of Benefits.

In an effort to continuously improve this product, CMS has set up a process to receive suggestions from providers, contractors, and CMS staff to enhance the functionality and effectiveness of the software. The next update will be available in July 2007. The MREP software maintainer (ViPs) will update the software to incorporate the improvements approved by CMS. Contractors will conduct testing of the updated software, and report issue(s) identified during the testing phase using the ViPs Assist Web site. Contractors will continue reporting any issue identified by them and/or providers once the new version goes into production through the ViPs Assist Web site.

This CR instructs about the MREP annual update mentioned in CR 5032. Please note that the timeline has changed from October to July for the annual enhancement update. In addition to the annual update, ViPs will provide 3 code updates to implement the Claim Adjustment Reason and Remittance Advice Remark code changes. These code sets are updated 3 times a year. A provider/supplier notification requirement will be included in Claim Adjustment Reason and Remittance Advice Remark code change requests which are issued three times a year. Unless any critical issue results in software update in the January, April, and October releases, the code update will be provided in a separate file to be used in conjunction with the existing version of the software.

B. **Policy:** Medicare contractors must use only currently valid CARCs in X12N transaction 835 (Health Care Claim Payment/Advice) version 004010A1, standard paper remittance advice, and X12 N transaction 837 COB version 004010A1. FISS and ViPs must make sure that any output using PC Print and MREP show only currently valid CARCs. Contractors must also use only currently valid RARCs in transaction 835 and standard paper remittance advice, and FISS and ViPs must make sure that any output using PC Print and MREP show only currently valid RARCs. These code sets are updated on a regular basis. Medicare contractors must make the necessary changes on a regular basis as per the recurring code update CR or the specific CR that describes the change in policy that resulted in the code change. The MREP maintainer ViPs will update the software every July, if needed. The list of enhancements is based on suggestions received from users, contractors and CMS, and is approved by CMS.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/B	DME	FI	CAR	DME	RHH	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5634.1	A/B MACs, carriers, DMERCs, DME MACs, FIs, RHHIs, VMS shall make necessary changes to ensure that at least one remittance advice remark code is reported if claim adjustment reason code 16 or 17 or 96 or 125 or A1 is used in 835, standard paper remittance advice, and any output using PC Print and/or MREP.	X	X	X	X	X	X	X				
5634.2	ViPs shall use RARC N130 with CARC 96 if appropriate									X		
5634.3	ViPS shall update the MREP software incorporating the improvements that have been approved by CMS.									X		
5634.4	A/B MACs, carriers, DMERCs, DME MACs, and ViPS shall test the new version.	X	X		X	X				X		
5634.5	VMS shall update the Medicare Remit Easy Print software to include the most current CARC and RARC lists available from the following Web site: http://www.wpc-edi.com/codes (Note: This update is provided in a separate file unless critical fixes are required for MREP that results in a new version of the software.)									X		
5634.6	A/B MACs, carriers, DMERCs, and DME MACs, shall notify the users that the code update file must be downloaded to be used in conjunction with the current software.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5634.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be	X	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. N/A

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, (410) 786-5155, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen, (410) 786-5155, sumita.sen@cms.hhs.gov

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:** No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC):***

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.