CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2996	**Date: July 25, 2014**
	Change Request 8855

SUBJECT: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

I. SUMMARY OF CHANGES: This CR updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs VIPs and FISS to update Medicare Remit Easy Print (MREP) and PC Print. This Recurring Update Notification applies to chapter 22, sections 40.5, 60.1, and 60.2.

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 6, 2014

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:
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 obliged 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:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2996	Date: July 25, 2014	Change Request: 8855

SUBJECT: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

EFFECTIVE DATE: October 1, 2014
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I. GENERAL INFORMATION

A. Background: 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) and appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. **SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC Web site.** If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC Web site.

The discrepancy between the dates may arise because the WPC Web site gets updated only 3 times a year and may not match the CMS release schedule. This recurring CR lists only the changes that have been approved since the last code update CR (CR 8703, Transmittal 2920, issued on April 4, 2014), and does not provide a complete list of codes for these two code sets. The MACs and the SSMs must get the complete list for both CARC and RARC from the WPC Web site that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts Remittance Advice code use.

WPC Web site address: **http://www.wpc-edi.com/Reference**

The WPC Web site has four listings available for both CARC and RARC.

NOTE I: In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented.

NOTE II: This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR **once.** If any modification or deactivation becomes effective at a future date, contractors must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC Web site.

NOTE III: The January recurring code update CR is assigned for MREP enhancements, and a log for requests/suggestions is created by VIPs. CMS reviews the log and prioritizes the requests. In order to follow the CMS release schedule, the cut off dates are May 15 for GDIT to receive requests, and July 15 for VIPs to develop and send the log to CMS.

B. Policy: For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used along with Group Code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information. If there is any adjustment, the appropriate Group Code must be reported. Additionally, for transaction 837 COB, CARC and RARC must be used. CARC and RARC code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see Business Requirements segment for explanation of conditions). Shared System Maintainers and contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation, even if not initiated by Medicare, will be implemented

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8855.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by October 6, 2014, per Attachment I and Attachment II for CARC and RARC changes respectively. **NOTE:** Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented **on the effective date** (which may be later than the implementation date mentioned in this CR) for those code modifications that are being used by Medicare.	X	X	X	X					
8855.2	B MACs, contractors and CEDI for DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the updated MREP software.		X							CEDI
8855.3	Contractors shall update reason and remark codes to include new codes that apply to Medicare by October 6, 2014, if and as instructed by CMS. See Attachment	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	I and II for CARC and RARC changes respectively since CR 8703. **NOTE**: Some new codes may become effective at a future date. Contractors shall make sure that new codes are implemented, if directed by CMS, on the effective date as posted on the WPC web site or later as directed									
8855.4	FISS, MCS, and VMS shall make necessary programming changes so that no deactivated reason and remark code is reported in the remittance advice and no deactivated reason code is reported in the COB claim by October 6, 2014. **NOTE**: Check the updated lists as posted on the WPC Web site to capture deactivations that were included in previous CR(s).					X	X	X		
8855.5	FISS, MCS, and VMS shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any standard code deactivated since the last update unavailable for use by the contractor by October 6, 2014.					X	X			
8855.6	FISS, MCS, and CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per this CR or as posted on the WPC Web site when: • Medicare is not primary; • The COB claim is received after the deactivation effective date; and • The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC Web site.					X	X			CEDI
8855.7	Contractors shall make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare Secondary Payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after deactivation date.					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8855.8	VMS shall update the Medicare Remit Easy Print (MREP) software by October 6, 2014. This update shall be based on the CARC and RARC lists as posted on WPC Web site on July 1, 2014.							X		
8855.9	FISS shall update the PC Print software by October 6, 2014. This update shall be based on the CARC and RARC lists as posted on WPC Web site on July 1, 2014.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8855.10	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 included in the contractor's 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.	X	X	X	X	X

IV. 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

V. CONTACTS

Pre-Implementation Contact(s): sumita sen, sumita.sen@cms.hhs.gov , Lauren Vandegrift, 410-786-7332 or lauren.vandegrift@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. 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: 2

CR 8855

ATTACHMENT I: Changes in CARC List since CR 8703

New Codes – CARC:

261	The procedure or service is inconsistent with the patient's history.	06/01/2014

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR) ***NOTES**: Not for use by Workers' Compensation payers; use code P3 instead.* ***CMS NOTE: This code was previously deactivated, however it is being reactivated.***	06/01/2014
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/01/2014
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/01/2014
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) ***NOTES**: To be used after the first month of the grace period.*	06/01/2014

Deactivated Codes – CARC

Code	Current Narrative	Effective Date

These are changes in the CARC database since the last code update CR 8703. The full CARC list must be downloaded from the WPC web site:
http://wpc-edi.com/Reference

CR 8855

ATTACHMENT II: Changes in RARC List since CR 8703

New Codes – RARC:

Code	Modified Narrative	Effective Date
	No new RARC codes were created	

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	07/01/2014
M77	Missing/incomplete/invalid/inappropriate place of service.	03/14/2014
M84	Medical code sets used must be the codes in effect at the time of service.	03/14/2014
MA100	Missing/incomplete/invalid date of current illness or symptoms.	03/14/2014
N202	Additional information/explanation will be sent separately.	03/14/2014
N203	Missing/incomplete/invalid anesthesia time/units.	03/14/2014
N205	Information provided was illegible.	03/14/2014
N208	Missing/incomplete/invalid DRG code.	03/14/2014
N210	Alert: You may appeal this decision.	03/14/2014
N211	Alert: You may not appeal this decision.	03/14/2014
N212	Charges processed under a Point of Service benefit.	03/14/2014
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	03/14/2014
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	03/14/2014
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	03/14/2014
N217	We pay only one site of service per provider per claim.	03/14/2014
N238	Incomplete/invalid physician certified plan of care.	03/14/2014
N245	Incomplete/invalid plan information for other insurance.	03/14/2014
N354	Incomplete/invalid invoice.	03/14/2014
N388	Missing/incomplete/invalid prescription number.	03/14/2014
N433	Resubmit this claim using only your National Provider Identifier (NPI).	03/14/2014
N438	This jurisdiction only accepts paper claims.	03/14/2014
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	03/14/2014
N467	Missing Tests and Analysis Report.	03/14/2014
N474	Incomplete/invalid certification.	03/14/2014
N476	Incomplete/invalid completed referral form.	03/14/2014
N478	Incomplete/invalid Dental Models.	03/14/2014

N482	Incomplete/invalid Models.	03/14/2014
N484	Incomplete/invalid Periodontal Charts.	03/14/2014
N488	Incomplete/invalid Prosthetics or Orthotics Certification.	03/14/2014
N490	Incomplete/invalid referral form.	03/14/2014
N543	Incomplete/invalid income verification.	03/14/2014
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected this will not be paid in the future.	03/14/2014
N554	Missing/Incomplete/Invalid Family Planning Indicator.	03/14/2014
N570	Missing/incomplete/invalid credentialing data.	03/14/2014
N609	80% of the provider's billed amount is being recommended for payment according to Act 6.	03/14/2014
N645	Mark-up allowance.	03/14/2014
N667	Missing prescription.	03/14/2014
N668	Incomplete/invalid prescription.	03/14/2014
N687	Alert: This reversal is due to a retroactive disenrollment.	03/14/2014
N688	Alert: This reversal is due to a medical or utilization review decision.	03/14/2014
N689	Alert: This reversal is due to a retroactive rate change.	03/14/2014
N690	Alert: This reversal is due to a provider submitted appeal.	03/14/2014
N691	Alert: This reversal is due to a patient submitted appeal.	03/14/2014
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.	03/14/2014
N693	Alert: This reversal is due to a cancellation of the claim by the provider.	03/14/2014
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.	03/14/2014
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.	03/14/2014
N698	Alert: This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.	03/14/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	03/14/2014

Deactivated Codes – RARC

Code	Current Narrative	Effective Date
	No RARCs were deactivated.	

These are changes in the RARC database since the last code update CR 8703. The full RARC list must be downloaded from the WPC web site:
http://wpc-edi.com/Reference