CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1087	**Date: OCTOBER 27, 2006**
	Change Request 5346

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

I. SUMMARY OF CHANGES: This Change Request instructs Medicare contractors and ViPs to update and use the most recent valid reason and remark codes in their electronic and paper remittance advice, Coordination of Benefit transactions, and Medicare Remit Easy Print software.

EFFECTIVE DATE: January 1, 2007
IMPLEMENTATION DATE: January 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: 1087	Date: October 27, 2006	Change Request: 5346

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

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.

X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. As the recognized maintainer of the RARC, CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from Medicare and non-Medicare entities. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may not impact Medicare.

Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding instructions, which implement 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 shall use the modified code even though the modification was not initiated by Medicare. If a new code is not initiated by Medicare, contractors do not have to use it unless they have received specific instruction from CMS to use it. A/B Medicare Administrative Contractors (A/B MACs), carriers, Durable Medical Equipment Regional Contractors (DMERCs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs) shall stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used. Medicare contractors shall not use any deactivated code past the deactivation date whether the deactivation is requested by Medicare or any other entity. The complete list of remark codes is available at:

http://www.wpc-edi.com/codes

The list is updated three times a year. By January 2, 2007 you must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes.

You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions. CMS has developed a new Web site to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site you can find some other information that is also available from the WPC Web site. The new Web site address is: http://www.cmsremarkcodes.info/

NOTE I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

NOTE II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N370	Billing exceeds the rental months covered/approved by the payer.	Yes
N371	Alert: title of this equipment must be transferred to the patient. *	Yes
N372	Only reasonable and necessary maintenance/service charges are covered.	Yes

* See NOTE II under X12N 835 Health Care Remittance Advice Remark Codes Section

Modified Codes

Code	Current Modified Narrative	Modification Date
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.	Modified eff. 8/1/06
M114	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.	Modified eff. 8/1/06
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	Modified eff. 8/1/06

Deactivated Codes

None

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year after each X12 trimester meeting. To access the list select http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in June 2006 are listed here. By January 2, 2007 you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions.

The request for a reason code change may come from either Medicare or non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to this regular code update notification. The regular code update notification is issued on a regular periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and **will establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.**

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements may be effective for a specified future and succeeding versions or on a specific date. Contractors can discontinue use of retired codes in prior versions or prior to the specific deactivation date. The regular code update notification will establish the deadline for Medicare contractors to retire a reason code. The Medicare deadline could be earlier than the version or the date specified in the Washington Publishing Company (WPC) posting. The committee approved the following reason code changes in June 2006.

Reason Code Changes

New Codes

Code	Current Narrative	Notes
196	Claim/service denied based on prior payer's coverage determination.	New as of 6/06

Modified Codes

Code	Current Narrative	Notes
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Changed as of 2/02 and 6/06
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Changed as of 2/02 and 6/06

96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Changed as of 2/02 and 6/06
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Changed as of 2/02 and 6/06

Retired Codes

Code	Current Narrative	Notes
43	Gramm-Rudman reduction.	Changed as of 6/06. This code will be deactivated on 7/1/2006

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 to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

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	
5346.1	A/B MACs, carriers, DMERCs, DME MACs, FIs, RHHIs and VMS shall update reason and remark codes that have been modified and apply to Medicare by January 2, 2007. .	X	X	X	X	X	X			X		
5346.2	A/B MACs, carriers, DMERCs, DME MACs, FIs, RHHIs and VMS shall update reason and remark codes to include new codes that apply to Medicare by January 2, 2007. .	X	X	X	X	X	X			X		
5346.3	A/B MACs, carriers, DMERCs, DME MACs, FIs, RHHIs and VMS shall update reason and remark codes that have been deactivated whether they apply to Medicare or not by January 2, 2007.	X	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	
5346.4	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 will be provided in a separate file starting in January, 2007.)									X		
5346.5	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. (Note: The software will be updated if there is any enhancement to be implemented. If there is no enhancement needed, the code update file will be used with the existing software).	X	X		X	X						

III. PROVIDER EDUCATION

Number	Requirement	Responsibility (place an "X" in each applicable column)										
Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5346.6	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 "MLNMatters" 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov **Post-Implementation Contact(s):** Sumita Sen, 410-786-5755, sumita.Sen@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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