CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1163	**Date: JANUARY 26, 2006**
	Change Request 5456

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.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *April 1, 2007
IMPLEMENTATION DATE: April 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: 1163	Date: January 26, 2007	Change Request: 5456

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

Effective Date: April 1, 2007

Implementation Date: April 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.

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.

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 3 times a year. By April 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
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. *Note: (New Code 12/1/06)*	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. *Note: (New Code 12/1/06)*	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. *Note: (New Code 12/1/06)*	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. *Note: (New Code 12/1/06)*	No
N377	Payment adjusted based on a processed replacement claim. *Note: (New Code 12/1/06)*	No
N378	Missing/incomplete/invalid prescription quantity. *Note: (New Code 12/1/06)*	No
N379	Claim level information does not match line level information. *Note: (New Code 12/1/06)*	No

Modified Codes

Code **Current Modified Narrative** **Modification Date**

M143	The provider must update license information with the payer. *Note: (Modified 12/1/06)*	12/01/06
N181	Additional information is required from another provider involved in this service. *Note: (New Code 2/28/03. Modified 12/1/06)*	12/01/06
N361	Payment adjusted based on multiple diagnostic imaging procedure rules *Note: (New Code 11/18/05. Modified 12/1/06)*	12/01/06

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 April 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
197	Payment denied/reduced for absence of precertification/authorization *Note: New as of 10/06*	New as of 10/06
198	Payment denied/reduced for exceeded, precertification/authorization *Note: New as of 10/06*	New as of 10/06
199	Revenue code and Procedure code do not match. *Note: New as of 10/06*	New as of 10/06

200	Expenses incurred during lapse in coverage *Note: New as of 10/06*	New as of 10/06
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR). *Note: New as of 10/06*	New as of 10/06

Modified Codes

Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. *Note: Changed as of 10/06. This code will be deactivated on 6/1/2007.*	Modified as of 10/06 Effective 6/1/2007
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). *Note: Changed as of 10/06*	Modified as of 10/06 Effective 6/1/2007 **Note: See Business Requirement 5456.4**
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. *Note: Changed as of 2/01 and 10/06. This code will be deactivated on 4/1/2007.*	Modified as of 10/06
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated *Note: Changed as of 2/99 and 10/06.*	Modified as of 10/06
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. *Note: Changed as of 6/03 and 10/06.*	Modified as of 10/06
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). *Note: Changed as of 6/00 and 10/06.*	Modified as of 10/06
196	Claim/service denied based on prior payer's coverage determination. *Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, on that date, begin to use value 136.*	Modified as of 10/06
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). *Note: Changed as of 10/06*	Modified as of 10/06
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. *Note: Changed as of 2/01 and 10/06.*	Modified as of 10/06
D17	Claim/Service has invalid non-covered days. *Note: This code will be deactivated on 2/1/2007. Use code 16 with appropriate claim payment remark code [M32, M33].*	Modified as of 10/06

D18	Claim/Service has missing diagnosis information. *Note: This code will be deactivated on 2/1/2007. Use code 16 with appropriate claim payment remark code [MA63, MA65].*	Modified as of 10/06
D19	Claim/Service lacks Physician/Operative or other supporting documentation *Note: This code will be deactivated on 2/1/2007. Use code 16 with appropriate claim payment remark code [M29, M30, M35, M66].*	Modified as of 10/06
D20	Claim/Service missing service/product information. *Note: This code will be deactivated on 2/1/2007. Use code 16 with appropriate claim payment remark code [M20, M67, M19, MA67].*	Modified as of 10/06
D21	This (these) diagnosis(es) is (are) missing or are invalid *Note: New as of 6/05. This code will be deactivated on 2/1/2007.*	Modified as of 10/06

Retired Codes

Code	**Current Narrative**	**Notes**
N/A		

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory 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	
5456.1	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 April 2, 2007.	X	X	X	X	X	X			X		
5456.2	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 April 2, 2007.	X	X	X	X	X	X			X		
5456.3	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 April 2, 2007.	X	X	X	X	X	X			X		
5456.4	Medicare contractors shall use code 45 in lieu of 42 effective 6/1/2007.	X	X	X	X	X	X			X		
5456.5	VMS shall update the Medicare Remit Easy Print									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	
	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 April, 2007.)											
5456.6	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. (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						
5456.7	If you find any discrepancy between any code text included in this CR and the corresponding text as posted on the Washington Publishing Company (WPC) Web site, use the text posted at the WPC Web site.	X	X	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	
5456.8	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 included in your next	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	
	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: N/A

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, 410-786-5755 sumita.sen@cms.hhs.gov
Tom Latella, 410-786-1310, thomas.latella@cms.hhs.gov --

Post-Implementation Contact(s): Sumita Sen, 410-786-5755 sumita.sen@cms.hhs.gov
Tom Latella, 410-786-1310, thomas.latella@cms.hhs.gov

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
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)*, use only one of the following statements:

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 specified 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.