CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1385	**Date: NOVEMBER 30, 2007**
	Change Request 5806

SUBJECT: Shared System Participation in Claim Adjustment Reason Code and Remittance Advice Remark Code Maintenance

I. SUMMARY OF CHANGES: This Change Request instructs the Shared System Maintainers (SSMs) and the contractors about the changed role of SSMs in maintaining the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) used in the remittance advice and COB claims.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *April 1, 2008
IMPLEMENTATION DATE: April 7, 2008

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
R	Chapter 22/60/60.1/Claim Adjustment Reason Codes

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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.

IV. ATTACHMENTS:

One-Time Notification

Manual Instruction

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1385	Date: November 30, 2007	Change Request: 5806

SUBJECT: Shared System Participation in Claim Adjustment Reason Code and Remittance Advice Remark Code Maintenance

EFFECTIVE DATE: April 1, 2008

IMPLEMENTATION DATE: April 7, 2008

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 both electronic and paper remittance advice and coordination of benefits transaction. Medicare policy further states that Remittance Advice Remark Codes (RARCs) are required in both electronic and paper remittance advice. Both these code sets are updated three times a year, and CMS publishes a recurring Change Request (CR) that lists changes in these two code lists since the last CR and sets the implementation date for Medicare contractors to start using the new or modified codes and stop using the deactivated codes in original business messages. There is usually a time difference between when these 2 code lists are published and/or effective and when Medicare contractors are instructed to implement because publication of these code lists do not necessarily align with Medicare release schedule. The current publication schedules are:

For CARC:

Around early March, July, and November

New codes are effective when published
Modifications are effective 6 months from approval
Deactivations are effective 6 months from approval

For RARC

Around early March, July, and November

New codes are effective when published
Modifications are effective when published
Deactivations are effective 6 months from publication

CARC and RARC updates published in March, July, and November should be included in recurring code update CRs for July, January, and April respectively. In addition to this recurring code update CR, a CMS component that has requested a change usually includes the code value in their CR that might have a different implementation date than the code update CR. Contractors shall follow the earlier of the 2 implementation dates if different. If a code is deactivated, Medicare may implement the deactivation before the stop date posted on WPC web site in order to follow the Medicare release schedule.

Medicare contractors are required to use only currently valid codes in remittance advice and coordination of benefit transactions, and update both code sets as stated, and be prepared to implement any emergency code change out of schedule, if needed.

Claim Adjustment Reason Codes: CARCs are updated three times a year and are maintained by the Claim Adjustment Status Code Committee comprising of payer, provider, and vendor representatives from the industry. The committee meets on Sunday before the X12 trimester conference. The CARC list is posted at http://www.wpc-edi.com/codes and includes start, last modified, and stop dates.

Explanation of Start, Last Modified, and Stop

- **Start**
  Every code has a Start date. This is the date when the code was first available in the code list.

- **Last Modified**
  When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.

- **Stop**
  When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a Claim Adjustment Reason Code with a Stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication (CLP02 values like "1", "2", "3" or "19"). The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication (CLP02 value "22"). The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835.

The CARC maintenance committee recently changed their policy about deactivation and made deactivation date specific rather than version specific. Now the deactivation becomes effective on a specific date (6 months from approval) rather than with a specific future version (e.g., version 5010) as was the case before. RARC deactivation was and is always date specific. The deactivation date is published on the WPC web site for both code sets.

CARCs are used in remittance advice and COB claim transaction, and Medicare contractors must use only currently valid CARCs. There could be some exceptions where a deactivated code may be reported e.g., 1) in case of a claim where Medicare is secondary, and the primary payer had used the deactivated code before the deactivation effective date, 2) a claim is being corrected and reversed, and the original processing was done before the deactivation effective date.

Currently the contractors have the responsibility to update these codes. But in some cases where a code has been hard coded by the Shared System(s), the contractors are unable to implement the deactivation. In order to resolve this issue, CMS has decided that **SSMs shall implement any deactivation from now on to make sure that**:

- The deactivated code is not used in original business messages on or before the stop date
- The deactivated code is still allowed to be processed if reported in a derivative business message

SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC web site.

Contractors shall continue to be responsible for updating for new codes and modifications. VIPs shall update the code file in conjunction with Medicare Remit Easy Print software.

SSMs also shall make sure that there is no size limitation restricting contractors to add new codes to any code table maintained by the Shared System. It has been brought to our attention that SPITAB table in MCS system has a limitation of 249 entries and currently there are close to 300 CARCs and over 700 RARCs. Both these code lists are also expected to expand in the future.

Remittance Advice Remark Codes: RARCs are updated three times a year and are maintained by CMS. The Remittance Advice Remark Code Committee composed of CMS staff from various components and a National Medicaid Electronic Data Interchange HIPAA Workgroup (NMEH) representative meets every month to review requests. Requests are sent using the WPC web site, and the RARC Committee recommendations are posted on WPC web site before they are incorporated in the updated list. This provides an opportunity to the industry to review and participate in the RARC maintenance process. The recurring code update CR that CMS publishes lists the changes in this code list in the last 4 months, and identifies new codes that are Medicare initiated. Contractors may but are not obligated to use new codes that are not Medicare initiated.

RARCs are used at both claim and line level, and any RARC can be used at either level. It has been brought to our attention that MCS and VIPs have some restriction about some specific RARCs that are not allowed to be used at the line level. SSMs shall remove any restriction in usage of both RARCs and CARCs to make sure that any CARC/RARC can be used at the claim and/or the line level when appropriate.

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 in case of new codes and modification of existing codes 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 Shared System Maintainers (SSMs) shall make necessary change when a code is deactivated so that the code is not allowed to be used in original business messages but allowed when reported in derivative business messages. The SSMs shall also review the codes that are hard coded to make sure that these codes are currently valid.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5806.1	The Shared System Maintainers shall implement any deactivation for claim adjustment reason and remittance advice remark code from now on to make sure that:						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	• the deactivated code is not used in original business messages on or before the stop date as posted on the WPC web site; • the deactivated code is still allowed to be processed if reported in a derivative business message • If Medicare is not primary and the COB claim is received after the deactivation effective date, and the date in DTP03 in Loop 2430 in COB 837 transaction is < the deactivation effective date as posted on the WPC web site, the claim shall be allowed to be processed. • In a Reversal and Correction situation, a value of 22 in CLP02 should identify the claim to be a corrected claim, and the deactivated code shall be allowed. **Note:** SSMs shall get the comprehensive list of deactivated codes from http://www.wpc-edi.com/Codes for implementation of this CR. Moving forward, the recurring code update CR will provide the information about deactivated codes, and SSMs shall compare the deactivation effective date posted at WPC with the CR implementation date. SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC web site.										
5806.2	The Shared System Maintainers shall remove any restriction that limits the number of codes that can be included in a code table for claim adjustment and remittance advice remark codes.						X	X	X		
5806.3	The Shared System Maintainers shall remove any restriction in contractor capability to use any claim adjustment reason or any remittance advice remark code at either claim or line level.						X	X	X		
5806.4	The Shared System Maintainers shall review codes that are hard coded, and make appropriate changes						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	per the recurring code update CR to make sure that only currently valid codes are used in remittance advice and coordination of benefits transaction.										
5806.5	A/B MACs, DME MACs, carriers, FIs, and RHHIs shall make necessary changes per the recurring code update CR or any other CR providing specific instruction about usage of CARC and/or RARC to assure appropriate and consistent use of currently valid codes. A/B MACs, DME MACs, carriers, FIs, and RHHIs shall also implement any emergency change, if needed, per CMS instruction.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

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Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

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

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen at 410-786-5755 or sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen at 410-786-5755 or sumita.sen@cms.hhs.gov

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and RHHIs:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC):
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC 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.

60.1 - Claim Adjustment Reason Codes

(Rev. 1385, Issued: 11-30-07, Effective: 04-01-08, Implementation: 04-07-08)

Claim Adjustment Reason Codes (CARCs) are used on the Medicare electronic and paper remittance advice, and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status Code Maintenance Committee maintains this code set. A new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare. This code set is updated three times a year. Medicare contractors shall use only most current valid codes in ERA, SPR, and COB claim transactions.

Any reference to procedures or services mentioned in the reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs).

These reason codes explain the reasons for any financial adjustments, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. Current 835 structure only allows one reason code to explain any one specific adjustment amount.

There are basic criteria that the Claim Adjustment Status Code Maintenance Committee considers when evaluating requests for new codes:

- Can the information be conveyed by the use or modification of an existing reason code?
- Is the information available elsewhere in the 835?
- Will the addition of the new reason code make any significant difference in the action taken by the provider who receives the message?

The list of Claim Adjustment Reason Codes can be found at:
http://www.wpc-edi.com/codes

The updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of *January/*February, June, and September/October. Medicare contractors must make sure that they are using the latest approved claim adjustment reason codes in ERA, SPR and COB transaction *by implementing necessary code changes as instructed in CMS Change Requests or downloading the list after each update. The Shared System Maintainers shall make sure that a deactivated code (either reason or remark) is not allowed to be used in any original business message, but is allowed and processed when reported in derivative business messages. Code deactivation may be implemented prior to the stop date posted at WPC web site to follow Medicare release schedule. SSMs shall implement*

deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC web site.

Contractors are responsible for entering claim adjustment reason code updates to their shared system and entry of parameters for shared system use to determine how and when particular codes are to be reported in remittance advice *and coordination of benefits* transactions. In most cases, reason and remark codes reported in remittance advice transactions are mapped to alternate codes used by a shared system. These shared system codes may exceed the number of the reason and remark codes approved for reporting in a remittance advice transaction. A particular 835 reason or remark code might be mapped to one or more shared system codes, or vice versa, making it difficult for a *contractor* to determine each of the internal codes that may be impacted by remark or reason code modification, retirement or addition.

Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a *contractor* can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual contractor searches to identify each affected internal code. Shared systems must also make sure that 5-position remark codes can be accommodated at both the claim and service level for 835 version 004010 onwards.

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the contractor manual transmittal or CMS recurring code update change request or the Medicare Claims Processing Manual transmittal that implemented a policy change that led to the issuance of the new or modified code. Contractors must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes.